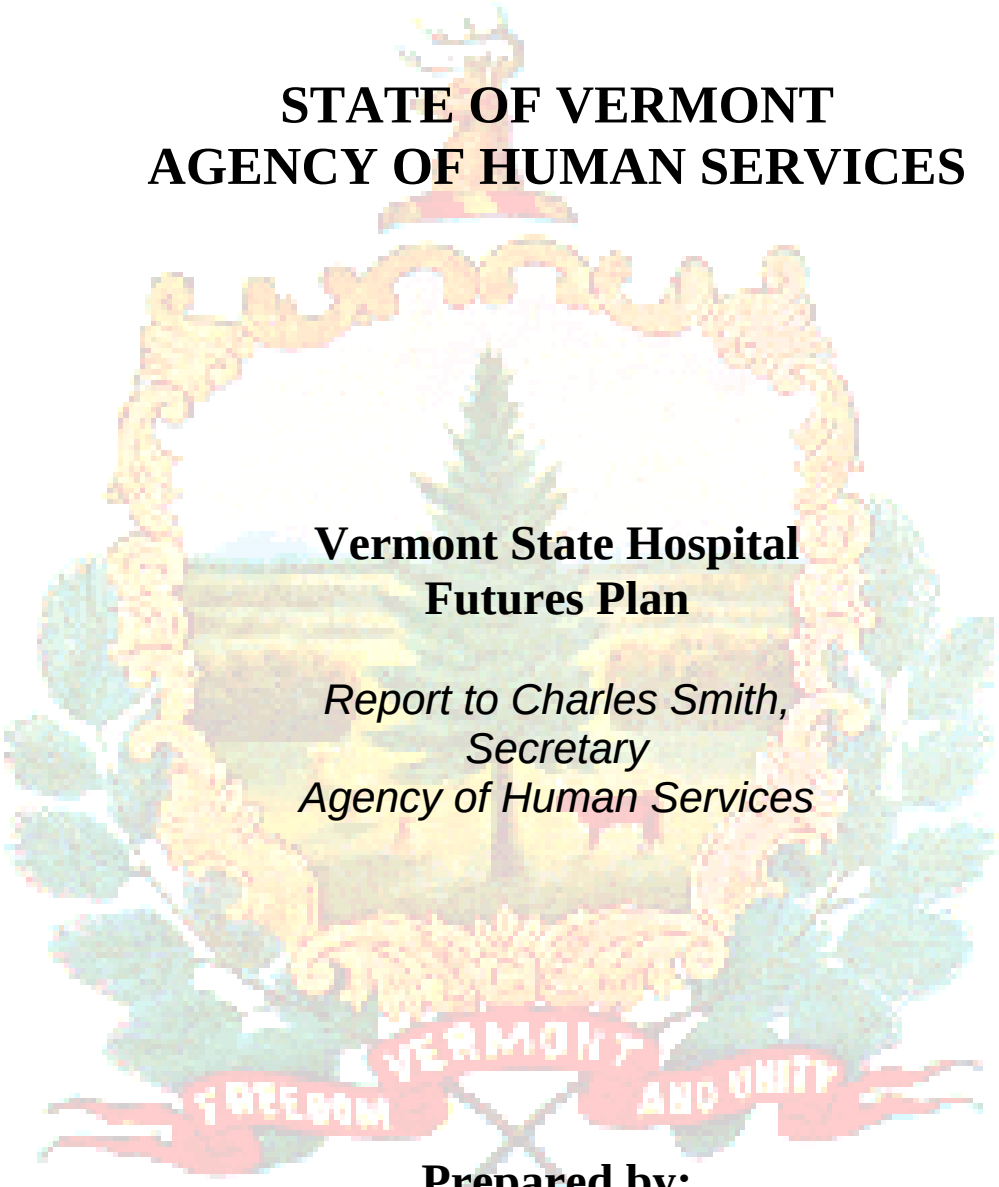
STATE OF VERMONT
AGENCY OF HUMAN SERVICES

Vermont State Hospital
Futures Plan

Report to Charles Smith,
Secretary
Agency of Human Services



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Authority and Scope

During its 2004 session, the Legislature set in motion a strategic planning process for the future of Vermont's public mental health system. The secretary of human services was charged with creating a comprehensive plan for the delivery of services currently provided by the Vermont State Hospital (VSH), within the context of long-range planning for a comprehensive continuum of care for mental health services. To accomplish this, the secretary was directed to establish an advisory group whose membership would represent all stakeholders in Vermont's mental health system and to consult with this group on all aspects of the strategic planning.[1] The legislation[2] gave the secretary and the advisory group nine guiding principles to direct its planning effort. The secretary directed the Division of Mental Health (DMH) to work with the advisory group to help frame this plan, an outline of which was presented to the Legislature's Mental Health Oversight Committee on October 15, 2004. The present report significantly advances the planning process reflected in the October report and is informed by the planning efforts of DMH and the advisory group.

The scope of this plan is limited to adults; it is acknowledged that the next steps need to include identifying the process for addressing adolescent, children and family mental health and substance abuse needs. Additional consideration should be given to the needs of seniors and of other special populations not specifically addressed in this report, including the needs of individuals who are deaf, autistic, developmentally disabled, or who have had traumatic brain injury.

Executive Summary

Over the past 20 years, Vermont has successfully moved towards its vision of deinstitutionalizing its programs and improving outcomes for persons with mental illness. Vermont compares favorably to other states in the New England region and the nation as a whole on measures of utilization and outcomes. In many areas, Vermont stands among the leaders in implementing nationally recognized best practices within its service delivery system for persons with mental illness, emotional disturbances, substance abuse treatment needs or developmental issues. VSH plays an important role in this overall mental health system of care. It provides a unique mix of acute and longer-term inpatient care and, because of its policy of never denying an eligible admission, it serves as the system's safety net.

Despite this overall favorable profile of Vermont's current service system, planning for the replacement of services currently provided at VSH is imperative for a number of reasons:

- Widespread recognition of the negative effects of institutional settings on a person's recovery, and of the inadequacy of the hospital's antiquated physical plant.

[1] In June, 2004, the previously existing Vermont State Hospital Advisory Group accepted the secretary's request to serve as the designated state hospital future planning advisory group, pursuant to last spring's legislation.
[2] House Bill 768 Section 141a (the "Big Bill").

- The scheduled loss over the next two years of federal funds representing more than half of the hospital's operating budget due to federal policy changes affecting all of the country's institutes for mental disease (IMDs), of which VSH is one.[3]
- Widespread recognition of the benefits of integrating psychiatric inpatient care with general inpatient medical services, and of the need to end VSH's historic isolation.

A number of principles and assumptions influenced the planning process and helped shape the outcome presented here. Key among them were:

- All people with psychiatric disabilities should have access to high quality, clinically appropriate care across a broad continuum of services.
- The State has ultimate responsibility for the provision and/or oversight of involuntary inpatient care.
- The existing VSH IMD model for provision of inpatient care is not economically viable.
- The provision of psychiatric inpatient services in a stand-alone IMD is not consistent with Vermont's policy of integrating mental health and general health care services.
- The expertise and experience of the current VSH staff is a valuable resource.
- Vermont's hospitals and designated agencies[4] (DAs) should play an expanded role in the future care of discrete populations.
- The State must remain committed to the principle of maintaining the locus of care in the community.

This plan calls for the development of an array of new and existing programs and it supports the use of public and private resources to serve the needs currently being provided at VSH, to ensure a full continuum of services in the most integrated and least restrictive environment, and to incorporate the needs of certain populations served by the Department of Corrections.

This plan is designed to maximize Medicaid and other federal receipts.

This plan proposes the closing of VSH and the distribution of VSH's current 54-bed capacity around the state and across programs offering different levels of care. It also calls for creating 10 new beds for care that meets individuals' needs without requiring them to be hospitalized. (Because these programs are designed to divert a significant portion of VSH's traditional caseload to non-hospital alternative care, they are called diversion programs and the beds are referred to here as diversion beds.) The plan also calls for increased spending on housing, transportation and legal services, enhanced peer resources and support, and a care management

[3] Section 1905(i) of Title XIX of the Social Security Act defines the term "institution for mental diseases" as "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases . . . ."

[4] A designated agency is a community mental health center designated by the Commissioner of Health (formerly by the Commissioner of Developmental and Mental Health Services) as the lead agency to provide comprehensive services to Vermont's priority mental health populations: adults with severe mental illness, individuals with developmental disabilities, and children and youth with severe emotional disturbances. (Designated agencies also are designated by the Commissioner of Aging and Independent Living to serve the developmentally disabled population.)

program that will ensure Vermonters have access to the appropriate level of treatment within a participating network of inpatient, crisis stabilization, residential, and outpatient services.

Here is the proposed breakdown of new and relocated beds:

1. **Secure residential (6 beds, relocated from VSH):** Six beds would be assigned to a secure residential program for individuals who are considered a danger to society and have been assigned to the custody of the commissioner, but who are not in need of hospital or sub-acute level care. For purposes of illustration, these beds are accounted for here as if they were in a single location, but that need not be the case. The secure residential program would probably be run by one or more DAs or other contractors, but could be run by DMH. The beds could be located anywhere in the state, although a central location with interstate highway access would be preferable. Final decisions regarding location(s) and operator(s) would depend on the outcome of an RFP process.

2. **Sub-acute care (16 beds, relocated from VSH):** Sixteen beds would be assigned to one or more sub-acute care programs for individuals who need intensive rehabilitation, but do not need to be hospitalized. For purposes of illustration, these beds are accounted for here as if they were in a single location, but that may not be the case. This program would be run by one or more DAs, hospitals, and/or other contractors[5] and would be run by DMH only as a last resort. The beds could be located anywhere in the state, although locations near population centers and/or interstate highways would be preferable. Final decisions regarding locations and operators would depend up the outcome of an RFP process.

3. **Inpatient beds, including psychiatric intensive care units (ICUs) (32 beds, relocated from VSH):** The remaining 32 beds relocated from VSH would be assigned to programs offering inpatient hospital care; 12 of these 32 beds would be assigned to intensive care units (ICUs). They could all be located in one location, or in as many as three locations. Final decisions regarding locations and operators would depend up the outcome of an RFP process. Here are some possible configurations, based on current institutional capacities and on expressions of interest in response to a recent RFI (all are clinically sound; to the extent financially possible, preference would be given to proposals that move us closer to our goal of providing individuals with treatment as close to home as possible):

    a. POSSIBLE SCENARIO: All 32 beds could be located at Fletcher Allen Health Care (FAHC), including 12 ICU beds.

    b. POSSIBLE SCENARIO: Thirty-two beds could be located at FAHC, including eight ICU beds. Four additional ICU beds could be added or reconfigured at Rutland Regional Medical Center or at Springfield Hospital.[6]

[5] As part of the terms of a contract to provide sub-acute services, a provider new to the system might become a Specialized Services Agency affiliated with, or independent from a DA.

[6] The addition of four ICU beds at either of these hospitals would allow for a reduction at FAHC to 28 beds or allow an expansion of overall capacity in the system.

c. POSSIBLE SCENARIO: Sixteen beds could be located at FAHC, including four ICU beds. Sixteen additional beds could be located on the campus of another hospital, including four ICUs. Two additional hospitals could each host an additional four ICU beds.

4. **Diversion (10 new beds):** Ten new diversion beds are planned to augment 19 existing diversion beds in programs run by DAs around the state. Currently, 19 diversion beds are used for crisis stabilization and hospital stepdown (Defined below. Under this plan, all diversion beds would be available for and adaptable to four types of care:

    a. **Triage and observation care (24 hours):** This new voluntary program would provide a brief haven for individuals who now are likely to be kept in hospital emergency departments pending referral. Individuals would remain in triage and observation until they had been assessed by an appropriately trained professional and either released or moved to another level of care.

    b. **Crisis stabilization care (24-48 hours):** This existing voluntary program currently offers care for up to two days, after which individuals typically either are stable enough to be released or are transferred to hospital care. Under this plan, individuals who have not stabilized might be transferred to a hospital if necessary, but most could be expected to qualify instead for a new hospital alternative level (defined below).

    c. **Hospital alternative care (3-7 days):** This existing voluntary program would focus on delivering professional care and peer support in a non-hospital setting, located as close to the individual's home community as possible.

    d. **Hospital stepdown care (24-72 hours):** This is a variation on an existing program. The capacity envisioned here would offer service for individuals transitioning to outpatient care and permanent housing. Persons in this stepdown program would typically begin the program upon release from a hospital and would be discharged at the end of their stay.

In addition to this distribution of VSH beds and creation of new diversion beds, the current plan calls for increased funding for several necessary support services.

- Recognizing that safe and adequate housing is crucial to our diversion goals and to the health of Vermonters dealing with mental health issues, this plan calls for a significant increase in support for housing for individuals in recovery.
- If the 32 inpatient hospital beds are distributed in more than one location, this plan would include additional costs for legal services, due to the higher costs of having attorneys consult with clients and witnesses in multiple locations.
- This plan includes funding for transportation costs, made necessary by the geographical distribution of programs.
- This plan includes added funding for care management, necessitated by the programmatic and geographical distribution of beds.

- This plan includes funding to augment current peer support programs and to develop new ones.

This plan anticipates affiliation of some of these services with academic partners. Any participation by FAHC would bring affiliation with the University of Vermont's College of Medicine. Any other participants that wished to affiliate themselves with UVM or with Dartmouth College's medical school would be encouraged to do so.

This plan would thus expand Vermont's private-public and academic partnerships, would meet the State's responsibility to provide or oversee involuntary care, would preserve the 54-bed capacity currently available at VSH, and would continue Vermont's progress toward our goal of ensuring high-quality clinical care in the least restrictive setting and most integrated fashion possible.

With the closing of VSH, we shall seize the opportunity to establish a state-of-the-art intensive care program, integrated into a mental health system that links prevention, early intervention, treatment, and on-going support programs, and that helps Vermonters with mental illness and emotional disturbances achieve full recovery.

Part I: Overview

> *"We envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports – essentials for living, working, learning, and participating fully in the community"*
>
> Achieving the Promise: Transforming Mental Health Care in America[7].

> *"Increased participation by consumers and families – in their own treatment plans, in the administration of services, and in the development of policy – has precipitated a change in culture of state-administered mental health services that now emphasizes recovery, resilience, and independence. These advances and others offer tremendous opportunities for reform.*"
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> National Association of State Mental Health Program Directors[8]

It has been more than 40 years since President John F. Kennedy called for a "bold new approach" to the delivery of mental health services, a community-based strategy that would offer an array of services responsive to different levels of disability and need, located close to where consumers live, and involving a new partnership among local, state and federal funding sources. In the decades that have followed President Kennedy's plea, the availability of community-based services has increased dramatically through the development of community mental health centers, and there has been a dramatic reduction in reliance on institutional care. Many individuals with severe and persistent mental illnesses now live full lives in the community and the disability rights and consumer movements have helped to establish the person with a psychiatric disability as a legitimate and necessary partner in the design and implementation of the mental health system.

The next wave of reform, recently articulated by both the World Health Organization[9] and the President's New Freedom Commission of 2003 (quoted above), emphasizes the importance of mental health to overall health, of prevention and early intervention, of having direct services and supports that are driven by those who use them, of simplifying the service system, and of ending disparities in access to care. This national movement of reform also emphasizes evidenced-based practices,[10] the recovery model,[11] and the use of technology to access mental

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[7] The President's New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America. Final Report, July 2003.

[8] National Association of State Mental Health Program Directors' response to President's New Freedom Commission

[9] See World Health Organization's 2001 report on mental health.

[10] See State Health Plan for further discussion of Evidence Based Practices.

[11] Recovery has many definitions. For one expert, it means "a process of learning to approach each day's challenges, overcome our disabilities, learn skills, live independently and contribute to society" [Ruth Ralph, quoted by the *NASMHPD/NTAC* (National Association of State Mental Health Program Directors/National Technical Assistance Center) *e-Report on Recovery* Home Page, www.nasmhpd.org/spec_e-report_fall04intro.cfm *e-Report*]. For others, recovery may be "the ability to live a fulfilling and productive life despite a disability." Or it may imply "the reduction or complete remission of symptoms. . . Having hope plays an integral role in an individual's recovery." (*NASMHPD/NTAC*, *Achieving the Promise*, p. 5.) Stressing independence, peer support, and community-based services, the recovery concept originated in the psychiatric survivor community, many members

health care and information. In addition, national mental health system reform identifies the importance of integrating substance abuse and mental health service, of understanding the prevalence of trauma, of the unique impact of trauma on people served in human service systems, and of the importance of developing supports and services that are trauma-informed and that support resilience in all individuals, families and communities.

We, Vermonters, hold a broad common vision regarding mental health care: we expect services to be of high quality and to be provided in a holistic, comprehensive continuum of care, where consumers are treated at all times with dignity and respect, where individual rights are protected, where public resources are allocated efficiently and produce the best positive outcomes, and where direct services overseen and provided by the Agency of Human Services and its community partners are person- and family-centered and driven, are accessible, and are culturally competent. We also share the understanding that all interventions must reflect the most integrated and least restrictive alternatives necessary.[12]

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of which had been institutionalized and were able with peer support to completely recover. They challenged the existing rehabilitation model of care, with its more modest goals of preparing individuals to work in closed workshops and live under supervision, an approach that carried with it the implication of lifelong illness, progressive disability, and ongoing need for treatment, frequently in an institution.

[12] Vermont has a long-standing commitment to the priority of community integration, safeguarding civil rights and involving stakeholders in the planning process. The commitment to stakeholder ownership in the process has been reiterated in policy and legislation. For example, the requirement that 51 percent of directors of community mental health center boards be consumers and family members, 18 V.S.A. 8909; Agency Rules on Designation requiring Statewide Program Standing Committees, with key participation in the re-designation process; and the requirements, in the 2004 planning legislation for VSH and for the community mental health centers, for active community stakeholder participation not only in the planning process, but in requiring that programs be designed under the principle of "ongoing consumer and community input with regard to program oversight and development," and with "consumers' participation in the development and implementation of their treatment plans." (Appropriations Act of 2004)

Part II: Policy Context

The planning for replacement of the functions currently performed at VSH is taking place at a time of unprecedented change in the delivery of Vermont's social services. A new State Health Plan will be delivered to the Legislature in coming weeks, a Health Resource Allocation Plan is due in July, and the Agency of Human Services is in the middle of a four-year effort to transform its role in the delivery of services. One reorganization outcome was the dissolution of the Department of Developmental and Mental Health Services and the relocation of the Division of Mental Health within the Department of Health. This change reflects the State's official endorsement of a public health approach to mental health treatment and care, and its recognition of the importance of addressing mental health issues in enabling Vermonters to lead healthy lives in healthy communities. Public health efforts focus on assisting individuals and communities acquire the knowledge and skills they need to thrive. With respect to the mental health system, this requires we continue support for the social, housing, employment and recovery education components of treatment and care.

By acknowledging that mental health is essential to overall health and by providing for better integration of mental health, substance abuse, and health care services,[13] it is hoped this aspect of the agency's reorganization will reduce the stigma often associated with mental illness,[14] and further advance the quest for full equity and parity. Additional planning efforts by Vermont's Olmstead Commission[15], the designated agency sustainability plan[16] and the Department of Corrections (DOC) mental health services plan[17] inform the recommendations contained herein.

Many of these efforts have common goals, which include:

- Increasing citizen's access to the services and healthcare that they want and need;
- Improving program quality and consumer satisfaction;
- Designing programs and services that are consumer and family driven;
- Insuring programs are responsive, sustainable and efficient over time;
- Improving the health and integration of citizens with disabilities in their home communities.

[13] See Appendix 1 for a description of two Department of Health Initiatives.

[14] Stigma refers to a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illnesses. Stigma is widespread in the United States and other Western nations. Stigma leads others to avoid living, socializing, or working with, renting to, or employing people with mental disorders - especially severe disorders, such as schizophrenia. It leads to low self-esteem, isolation, and hopelessness. It deters the public from seeking and wanting to pay for care. Responding to stigma, people with mental health problems internalize public attitudes and become so embarrassed or ashamed that they often conceal symptoms and fail to seek treatment.

[15] In June 2002, the Legislature enacted S.224, adding Section 21 to 3 V.S.A. § 3096 to establish Vermont's Olmstead Advisory Commission. The legislation called for the commission to assist the agency in developing a comprehensive, effectively working plan for placing qualified people with disabilities in the most integrated community settings. The catalyst for the legislation, and the commission's creation, was the United States Supreme Court ruling in *L.C. and E.E. vs. Olmstead, June 1999.* Vermont's Olmstead Commission is in the midst of putting together Vermont's plan, which is due to the Legislature by July 2005.

[16] Vermont's Designated Agency System for Mental Health, Substance Abuse and Developmental Services System Evaluation & Five-Year Projection of Service Demand and Analysis, Pacific Health Policy Group, Nov. 1, 2004.

[17] Forthcoming.

Planning for the future of the mental health care system is based on nine considerations outlined by the Legislature, which reflect the commonly held values of the agency and the mental health provider and stakeholder communities:

(1) an understanding of the role of active treatment in the goal of recovery;
(2) an understanding of the role of trauma in the lives of individuals;
(3) accessible general medical care;
(4) minimal use of involuntary interventions such as seclusion, restraint, and involuntary medication;
(5) staff training in the use of safe and appropriate alternatives to involuntary interventions;
(6) consumers' participation in the development and implementation of their treatment plans;
(7) consumers' right to privacy and the right to have information regarding their care remain confidential, unless disclosure is authorized by the consumer or required under the law;
(8) ongoing consumer and community input with regard to program oversight and development; and
(9) accountability for all components of the mental health care system.

In addition to establishing parameters for planning for the replacement of services at VSH, the legislation also required that an advisory group representing various stakeholders give input to the human services secretary.[18] The Vermont State Hospital Advisory Group has been meeting approximately twice a month since June, 2004.

Specific Policy Considerations

The VSH is a 113-year-old institution for psychiatric care. At its height, in 1952, the average daily census was 1,350 patients. As the VSH downsized, there was commensurate growth in the community-based programs. Funds previously used to support the hospital were matched with money from the federal Medicaid program to support these programs. These community services and supports have continued to grow, allowing almost all individuals who experience mental illness to lead full, productive lives in the community. By the late 1990s, as the Dean Administration worked to close the Dale Unit[19] at VSH, a significant investment in new, voluntary community services was made once again. Between 2000 and 2004, the average daily in-house census at VSH stabilized at 45-50.

An unintended consequence of Vermont's emphasis on community treatment was chronic under-funding of VSH. The hospital lost its certification from the Centers for Medicare and Medicaid Services (CMS) in September of 2003 following two patient suicides and a series of failed inspections. The hospital regained this certification and federal funding in November, 2004.

Even in the face of continuing investments in renovation, the VSH facility in Waterbury remains inadequate. The buildings are old and the rooms narrow, with poor heating and ventilation

[18] In June, 2004, the previously existing Vermont State Hospital Advisory Group accepted the secretary's request to serve as the designated state hospital future planning advisory group, pursuant the legislation. A list of the members can be found in the Appendix.
[19] The Dale unit did not directly serve admissions; rather, long-stay VSH patients were transferred to the program after many months in the hospital.

systems. All units are cramped and there are no comfortable places for family visiting, program activities or physical activity. The space for patients to meet with professional staff, for individual counseling, for instance, is also inadequate. There are no quiet areas designed for patients who want time alone, away from others who are agitated, loud, or in other ways disruptive. There is little natural lighting in rooms or hallways, and the hallways are too narrow to allow for the transfer of restrained patients on regular beds; bath and toilet facilities are not available in the rooms, but are in one location with multiple toilets and showers.

An institutional culture has developed over time at VSH, characterized by relative isolation and segregation from community mental health and general hospital services. Vermont's community and inpatient mental health providers, meanwhile, rely on VSH as a safety net and currently lack the clinical and physical security capacity for the VSH level of care.

Finally, a shift in Medicaid policy lends urgency to the need for reform. The federal Medicaid program does not reimburse care for individuals over the age of 21 years and under the age of 65 in an institute for mental disease (IMD), which is defined as a free-standing hospital of more than 16 beds that is designed primarily for psychiatric care. The VSH is one of two Vermont facilities[20] classified by CMS as an IMD. Under the terms of the 1115 Medicaid waiver,[21] Vermont negotiated an exception to the IMD exclusion in 1995 to allow the state to include a portion of the costs at VSH under the managed Medicaid program for Vermonters eligible for services in Community Rehabilitation and Treatment programs (CRT).[22] The federal government is rescinding this waiver of the IMD exclusion beginning in calendar year (CY) 2005. This will amount to a loss in federal receipts as follows:

CY 2004 – 100% payment for IMD coverage
CY 2005 – 50% payment for IMD coverage
CY 2006 – 0% payment for IMD coverage

In SFY[23] 04, the operating cost for VSH was $13,520,510. The projected Medicaid receipts, through the 1115 waiver, for SFY 04 was $7,045,510.[24] If the VSH continues to operate as an

[20] Retreat HealthCare in Brattleboro is Vermont's other IMD.
[21] The 1115 B Waiver is a negotiated exception to the typical rules of the federal Medicaid program. There are several types of Medicaid waivers, including Home and Community-Based Waivers, 1915 B Research Demonstration Waivers, and 1115 B Freedom of Choice Waivers. In this context, the Medicaid waiver is Vermont's 1115 B Freedom of Choice Waiver to expand health care access to previously uninsured Vermonters, called the Vermont Health Access Plan (VHAP). Under the terms of this waiver, in addition to creating the VHAP health insurance plan, Vermont negotiated a "waiver of the IMD exclusion" and developed capitated payment system for community and inpatient services for adults with severe and persistent mental illnesses. The Division of Mental Health became the administrative entity responsible for operating a pre-paid inpatient behavioral health Medicaid managed care plan.
[22] Community Rehabilitation and Treatment programs offer a full range of mental-health supports and services for adults with diagnoses of major mental illnesses such as schizophrenia, bipolar disorder, major depression, and serious disorder of thought or mood. In addition to diagnosis, criteria for enrollment in a CRT program involve long-term disability (as evidenced by social isolation or poor social functioning, a poor work history, or Supplemental Security Income) and a recent history of intensive and ongoing mental-health treatment (multiple psychiatric hospitalizations, for example, or six consecutive months of outpatient treatment).
[23] The State Fiscal Year (SFY) runs from July 1 to June 30th and is therefore different from the calendar year.
[24] The de-certification of VSH in SFY 04 prevented Vermont from realizing these receipts; however, with recertification, these receipts can now be claimed through the phase out period described above.

IMD at its current size, these federal receipts would need to be replaced with state funds by January 2006.

Addressing these issues will require significant enhancement of the relationships among general hospitals, VSH and the community providers. Because the current facility is antiquated and does not conform architecturally to current inpatient standards, it must be closed. The closing of VSH gives Vermont a rare opportunity to establish a state-of-the-art intensive care program.

Part III – Current System of Care and Recommendations

This section reviews the current system of care, identifies gaps and opportunities, and sets out in general terms the secretary's recommendations. The service system components are broadly divided into inpatient services and community services, which include legal, transportation, and peer resource services.

Overview Of the Current Mental Health Service System

Vermont's publicly funded mental health services system, which is primarily funded by Medicaid, is overseen by the Division of Mental Health, which is part of the agency's Department of Health. Medicaid is overseen by the agency's Office of Vermont Health Access, commonly known as OVHA. The system includes VSH, five designated hospitals,[25] and 11 community agencies designated[26] to provide services to adults with severe mental illnesses, children with severe emotional disturbances, and individuals with developmental disabilities. The present plan focuses on the first of these three groups.

Also participating in the publicly funded system are more than 800 individual practitioners who participate in the Medicaid program as mental health providers. Any enrolled Vermonter may access mental health services from these practitioners. In addition, many Vermonters seek mental health care, often in the form of medications from their primary care physicians. Medicaid claims data indicate that primary care physicians write more prescriptions for psychotropic medications than any other group in Vermont. Finally, many individuals seek publicly funded care from hospital emergency rooms.

In addition, there is a privately funded system of individual and group practices, paid for primarily through private employer-based health plans.

A full inventory of Vermont's health care system, including mental health and substance abuse services, is underway as part of the Health Resource Allocation Plan mentioned above.

Inpatient Services

Involuntary Inpatient Care

There are 126 psychiatric inpatient beds in the state's designated hospitals (DHs), 54 beds at VSH and 12 beds at the White River Junction Veterans Hospital,[27] for a total of 192 adult

[25] A designated hospital is a general hospital with psychiatric inpatient services that is designated by the Commissioner of Health (formerly Commissioner of Developmental and Mental Health Services) to provide treatment to individuals involuntarily committed to the Commissioner's care and custody.

[26] A designated agency is a community mental health center designated by the commissioners of health and of aging and independent living (formerly the commissioner of developmental and mental health services) as the lead agency to provide comprehensive services in a specific geographic area to Vermont's priority mental health populations: adults with severe mental illnesses, individuals with developmental disabilities, and children and youth with severe emotional disturbances.

[27] The services at the White River Junction Veterans Hospital are available only to Veterans and only on a voluntary basis.

psychiatric inpatient beds within the state. Vermonters also use hospital-based psychiatric services in neighboring states[28] (primarily Dartmouth Hitchcock). Within this broad capacity for inpatient care, the division of mental health (DMH) oversees a network of hospitals designated to accommodate involuntary care,[29] with patients hospitalized in locations as close as possible to their home community. These partnerships between DMH and the hospitals began in 1994 and have led to a significant shift in the number of involuntary admissions away from VSH.

In 1994, the average daily census at VSH was 76. In conjunction with the closing of the VSH Nursing Home and the Dale 3 Unit, more hospitals became designated to provide treatment for people admitted on emergency examinations status and the VSH census dropped to below 50. Since SFY 2002, VSH average daily census has ranged from 46-48. The maximum VSH census is capped by bed capacity (54). A process for diversion back to designated hospitals and DA programs is triggered when the census approaches 50. This situation occurred approximately 30 times in the past two years.

There were 252 admissions of adults to DHs for emergency examinations in SFY 2004. In addition, there were 250 admissions of CRT clients with Medicaid coverage for voluntary inpatient hospitalization in DHs and out-of-state hospitals.

Virtually all of Vermont's DH psychiatric units are locked[30] and are designated to provide involuntary treatment. Although successful intervention appears to be occurring in designated hospitals, the evidence is unclear as to how well we are meeting the original goals: reducing the VSH census, reducing involuntary care overall, and providing treatment closer to home.

In addition, since assuming responsibility for decisions concerning one's treatment is empowering and important for recovery, DMH must find ways to address this issue as we move forward with a more decentralized system of care.

The geographical spread of the DH system has raised concerns about supervision and consistency of efforts to reduce seclusion and restraint (including emergency involuntary medications). Recent reports indicate that despite relatively low numbers, the *rate* of involuntary emergency procedures is higher in the general hospitals than at VSH.

It's clear there has been a reduction in the VSH census in recent years and that CRT clients are served closer to home. The extent to which this is the direct result of the policies established in the 1990s is suggested but unproven. On the other hand, no overall reduction in the number of people receiving involuntary inpatient care has occurred.

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[28] In CY 2002, Vermonters used 55,501 inpatient bed days for mental health treatment, of which 4,941 were provided in out-of-state hospitals, for an average daily census of 14 Vermonters in out-of-state hospitals. The in-state average daily census was 152 during this same period.

[29] In accordance with Vermont statutes governing the emergency examination and commitment of individuals with mental illness.

[30] The Smith 4 Program at Fletcher Allen Health Care is not routinely locked. The fact that the rest are locked is an unintended consequence of transferring involuntary care to DHs.

VSH Role and Population Served

As noted above, VSH currently is the only hospital in the system that has a no-reject admission policy. It plays a unique safety net function in Vermont's overall system of care; it historically has provided care to individuals with higher acuity, greater risk for dangerous behavior, longer term stays and/or who require involuntary medications under ACT 114.[31] It also has been the only location for inpatient competency and sanity evaluations for individuals charged with a crime.

In the current system, all emergency examinations (EEs)[32] are first proposed for admission to DHs, and if these hospitals decide not to admit, then the patient is referred to VSH. Therefore, all EE admissions to VSH have been refused by DHs. This represents between 84 and 115 admissions per year. The most frequent reasons cited by DHs for refusing proposed EE admissions are "the patient's behavior" or that admitting the patient would render the "acuity of the unit" too high to safely manage. The DMH and the DHs have specifically agreed that, in the current system, DHs have the option to decline an admission they do not feel they can safely treat.

Table 1 shows a 10-year history of the admissions to VSH and their legal status. While VSH is distinguished from other psychiatric inpatient programs by its focus on involuntary care, if other options were available, it is likely that some of the care currently delivered at VSH on an involuntary status could be provided in alternative programs on a voluntary basis. Vermont has an important opportunity to plan for replacement services that are voluntary.

Table 1: Vermont State Hospital Admissions Legal Status
Fiscal Years 1995 – 2004

Fiscal Year	Total Admissions	Voluntary Admissions		Emergency Admissions		Forensic Admissions		Other Admissions[33]	
2004	219	13	6%	95	43%	103	47%	8	4%
2003	216	16	7%	84	39%	104	48%	12	6%
2002	240	14	6%	115	48%	97	40%	14	6%
2001	221	8	4%	100	45%	106	48%	7	3%
2000	224	10	4%	114	51%	84	38%	16	7%
1999	224	5	2%	90	40%	115	51%	15	7%
1998	304	6	2%	161	53%	122	40%	15	5%
1997	302	11	4%	152	50%	115	38%	24	8%
1996	289	3	1%	178	62%	86	30%	22	7%
1995	313	9	3%	189	60%	95	30%	20	7%

[31] Act 114 sets out the legal process and implementation procedures for the provision of non-emergency involuntary psychiatric medications.

[32] Admissions for Emergency Examinations (EE) occur upon written application by an interested party (usually the DA screener), accompanied by a certificate signed by a physician who is not the applicant. The application sets forth facts and circumstances that indicate the need for an emergency examination according to the following standards: the person must have mental illness, be in need of treatment, and be dangerous to self or others, and it must be the case that no less-restrictive alternative is sufficient.

[33] "Other" admissions are all involuntary and refer to revocation of conditional release, revocation of orders of non-hospitalization and inter-state transfers.

In addition to VSH's being primarily a site for involuntary treatment, very few of the patients served at VSH have private health insurance. In SFY 04, only 4 percent of the total bed days (17,051) were supported by third party insurance and 31 percent of the bed days had no source of payment.

Three years (SFY 02-04) of census trends were used to develop an estimate of overall bed capacity needed to replace VSH. Based on the maximum daily census experienced, a VSH replacement requires a 57-bed capacity. A calculation using the actual standard deviation for census yields a 54-bed capacity. A formula[34] recommended for calculating needed capacity at general hospitals, when applied to VSH's current 54 beds, shows that a 61-bed capacity would be required. (See Appendix 2) However, these estimates do not reflect the fact that not all patients at VSH may actually require inpatient care.

The population served at VSH is not static, and the needs of individuals fluctuate over the course of hospitalization. There are many ways to analyze this population: length of stay, point of entry, diagnostic groupings, level of dangerousness towards self or others, forensic status, and so forth.

The groupings below cluster around the length of stay and the degree to which patient behaviors present the risk of dangerousness. They are not diagnosis specific and include individuals with traumatic brain injuries (TBI) and other brain injuries, individuals with co-occurring substance abuse disorders, individuals with mental illness and developmental disorders. The services proposed in this plan need to be clinically and programmatically capable of serving individuals with multiple diagnoses.[35] The rate of co-occurring conditions among VSH patients is very high. Substance abuse was identified as a factor in 60 percent of the admissions in SFY 04 and complex health conditions abound. Equally important is the expected extremely high rate of patients with significant trauma histories. VSH does not systematically collect data on trauma but the National Trauma Consortium estimates that as many as 80 percent of men and women in psychiatric hospitals have experienced physical or sexual abuse, most as children. This is particularly of concern in an involuntary treatment program in which the very factors that contribute to resilience and healing: choice, control, informed consent, collaboration and the sharing of power, are often undermined. Screening for trauma should become a priority throughout the system in the immediate future.

The individuals for whom VSH currently provides services can be roughly divided into four clinical groupings.[36]

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[34] Average Daily Census (ADC) + 1.65 times the square root of the ADC. This formula assures a 95% confidence level that a bed would be available when needed. This formula applied to the system as a whole shows that a system bed capacity of 101 beds are needed. This is discussed later in the document.

[35] There are generally not enough patients in any one of these discrete diagnostic groupings to create a specialty program, and the creation of separate psychiatric inpatient units for discrete populations of individuals with neuropsychiatric disorders such as TBI is not recommended.

[36] These groupings are derived from daily census data, admissions data, and multiple point-in-time analyses of the VSH population over the past 18 months. The planning assumptions in this document are also informed by analyses of cases in which patients have been turned away from DHs and Retreat Healthcare. Analyses requiring integration of patients' legal status and clinical care are currently under development. Significant gaps in available data make it difficult to quantify the experience of mental health patients not in the custody of the commissioner of health.

- Individuals who are now psychiatrically stable, but who have been charged with serious crimes and whose stay is at the discretion of the courts or due to community resistance to alternative placement. These individuals currently may not require an inpatient level of care but do require settings sufficiently contained and supervised to assure that public safety is not at risk. As an alternative way to meet the needs of this group, a secure residential treatment program is recommended in Part IV of this document. On average, this group consists of six individuals.

- Individuals requiring more than 30 days of intensive inpatient care. The average length of stay at DH psychiatric programs over the past 10 years has been between seven and nine days. During the same time period, the average length of stay at VSH has ranged from 63 to 76 days. Individuals staying longer than one month account for 60 percent of the VSH bed days. The wide variance in length of stay between VSH and the other Vermont inpatient programs points to different care practices and also to different clinical needs of the populations served. These individuals require intensive, multi-disciplinary treatment in a secure inpatient setting.[37] They are at high risk for dangerous behavior such as suicide and assault, may need intensive medical care, and may require non-emergency, involuntary medication to ameliorate symptoms and restore capacity.[38] Individuals with psychiatric disabilities who are currently incarcerated and in need of inpatient care could be among those who meet this description. Longer length of stay in these cases does not represent treatment failure. Ways to meet the needs of this group are described in Part IV under the specialized inpatient unit. On average, this group consists of 20 individuals.

- Individuals requiring brief, intensive, inpatient care. These individuals also require intensive, multi-disciplinary treatment in a secure inpatient setting. Individuals with psychiatric disabilities who are currently incarcerated and in need of inpatient care could be among those who meet this description. The clinical emphasis is on assessment and the development of a treatment plan to stabilize symptoms and to move the patient out to an appropriate, less restrictive and more integrated level of inpatient, rehabilitation, or community care, or to return the patient to the Department of Corrections. Alternative ways to meet the needs of this group are recommended in Part IV, under the specialized inpatient unit option with a psychiatric intensive care unit. On average, this group consists of 12 individuals.

- Individuals requiring longer-term rehabilitation services to restore their capacity to function in the community. These individuals have serious and persistent mental illnesses that have proven refractory to treatment, have high rates of recidivism and have histories of lengthy hospitalization. They require intensive, sub-acute, multi-disciplinary rehabilitation services with an emphasis on restoration of the skills needed for community living. The length of stay may be months or longer, and motivational enhancement and recovery-oriented services

[37] "Intensive, multi-disciplinary treatment in a secure inpatient setting" consists of state-of-the-art diagnostic, behavioral, motivational engagement, and medical services, all provided in a continuous and ongoing manner.
[38] Having this capacity is not the same as accepting medication. Having capacity means having the ability to make an informed choice about accepting or rejecting the treatment proposed. Involuntary treatment is strongly opposed by some advisory group members and its avoidance is articulated in law as a state policy. 18 V.S.A. 7629. The agency is committed to the goal of achieving a system of care that is free of coercion, ensuring that individuals have protection of their right to refuse treatment, and ensuring that individuals who lack capacity to consent to treatment have recourse to appropriate surrogate decision-making.

are emphasized. It is likely that, in a less-institutional and more community oriented environment, much of the current long-stay population might voluntarily agree to rehabilitation and treatment programming. On average, this group consists of 16 individuals.

Additional Considerations

Psychiatric Inpatient Services for Incarcerated Individuals

DOC has a small population, variously estimated[39] from four to ten persons, for whom there is no appropriate inpatient service site. These individuals are in the care and custody of the corrections commissioner, are incarcerated, acutely ill and in need of hospitalization. They cannot be appropriately placed because current inpatient sites lack sufficient security to protect care givers, other patients, and the therapeutic environment. The number of psychiatric intensive care unit (ICU) beds proposed in Part IV of this document address the needs of this small population.

DOC also has a population, as yet to be quantified, of individuals with moderate to severe emotional disturbances who are in need of therapeutic intervention, but who are not in need of hospitalization. Programming for this population is being developed as part of the DOC mental health plan.

Provision of non-emergency involuntary psychiatric medication under Act 114.[40]

VSH is the only program in which non-emergency involuntary medication under the terms of Act 114 is provided. As part of the transition towards the closing of VSH, planning will need to occur regarding the appropriate circumstances for the implementation of Act 114 at particular DHs. Table 2 shows the number of petitions for non-emergency involuntary medication filed during the past four years.

Table 2: Non-Emergency Involuntary Medication Petitions Filed

SFY '02 = 27	July 1, 2001 – June 30, 2002 [1]	
SFY '03 = 21	July 1, 2002 – June 30, 2003	[2]
SFY '04 = 27	July 1, 2003 – June 30, 2004	
SFY '05 = 14	July 1, 2004 – Dec. 14, 2004	

[1] 12/05/02 The first petition under Act 114 was filed.

[2] 8 of these petitions were filed on the same 4 people, each reflecting an initial 90 day order and a renewal.

Provision of inpatient evaluation and treatment for individuals charged with a crime.

[39] The advisory group found the methodology used by DOC to arrive at this estimate to be controversial and expressed concern that it underestimates the need for psychiatric inpatient services. This estimate is further complicated by the belief shared by many advisory group members that there is a much larger DOC population that is underserved and would benefit from more intensive and comprehensive mental health services. The estimate of four to 10 people in DOC custody in need of psychiatric inpatient care is based on the historical experience of DOC officials and the mental health service providers under DOC contract.

[40] Act 114 sets out the legal process and implementation procedures for non-emergency, involuntary psychiatric medications.

One of the more complex questions under consideration has been the issue of forensic admissions to VSH. For the purpose of discussion, forensic admissions refer to court-ordered observation evaluations that are performed in an inpatient setting. An independent forensic psychiatrist sees the defendant to determine if he or she was insane at the time of the alleged offense, had the mental state required for the offense charged, and/or is competent to stand trial for the alleged offense. Admissions for observation occur when a district court sends a criminal defendant to VSH for a psychiatric evaluation. The courts are expected to consult with a qualified mental health professional about the most appropriate site for the forensic evaluation to occur (namely, at VSH, in the community or in jail)[41]. In SFY 04, the courts commissioned 269 observation evaluations, of which 38 percent were completed at VSH, 42 percent in the community, and 20 percent in jail.[42]

As Table 1 shows, over the past 10 years, forensic admissions account for between 30 and 50 percent of all admissions to VSH. For those evaluations that occur at VSH, if the evaluator finds that the defendant is sane and competent, a hearing is held within 48 hours, and the defendant is returned to DOC oversight. If the finding is that the defendant is incompetent to stand trial, an involuntary hospitalization hearing is held and the person is usually committed to VSH for treatment. Forensic admissions generally account for just under 50 percent[43] of all VSH admissions (See Table 1), and the number of these admissions has historically been fairly consistent. During the past four years, for instance, the number of observation admissions to VSH has ranged from 97-106. While the number of observation admissions has remained constant, these admissions have increased as a percentage of overall admissions because overall admissions have declined due to the diversion of emergency evaluations (non-court referral) admissions to the DHs.

No other hospital in Vermont provides psychiatric inpatient services to this population. The advisory group has considered whether or not separate programs should be created for forensic admissions and remains divided on the issue. Concerns raised included:

- Forensic populations are more likely to be dangerous.
- Mixing alleged violent offenders with trauma survivors and other psychiatric inpatients creates an adverse environment for recovery.
- Decisions to pursue charges in the first place are discretionary and practices vary by jurisdiction.
- A mixed program might criminalize people who, except for their mental illness, would be unlikely to be involved in the criminal justice system.
- Creation of separate programs may inevitably lead to unequal standards of care and resources.

[41] An analysis conducted in 2009 revealed that judges and screeners disagreed about 14% of the time.
[42] Of those admitted in SFY 03 on observation status, almost half (51 admissions) were found sane and competent; these accounted for an average daily census of three beds and an average length of stay of 18 days. In most of these instances, a qualified mental health professional had recommended that the evaluation occur on an inpatient basis, indicating that these individuals were, from a clinical perspective, in need of acute psychiatric treatment. The qualified mental health professionals use the following standard in arriving at their recommendation: the person must be mentally ill, in need of treatment, and no less restrictive environment would be appropriate.
[43] In SFY 04 there were 103 observation admissions to VSH out of a total of 219 admissions.

During SFY 03[44], 99 people had a total of 103 admissions for observation evaluation at VSH. Most (60 percent) were discharged within one month. Four out of five were men. An analysis of their charges shows that most were charged with misdemeanors (80 people) while 27 had felony charges.[45] Dividing both felony and misdemeanor charges into the categories of violent and non-violent showed that in SFY 03, most of the observation admissions (60 percent) were for non-violent charges and 40 percent were for violent charges. Ten observation admissions were associated with both violent and non-violent charges. (See Appendices 3 and 4).

However, if the administration of emergency involuntary interventions (seclusion, restraint, medications) is used as a proxy for "dangerousness" at VSH, the data show that those charged with violent felonies were the least likely to require emergency involuntary interventions.[46] In fact, people admitted on observation status were less likely to receive emergency involuntary interventions than were people admitted on emergency exam status. Among those admitted for observation evaluations, the rate of emergency involuntary interventions was the highest for individuals charged with misdemeanors and it did not vary significantly between violent and non violent misdemeanors.

Based on this analysis, and the experience of operating the VSH, there is little justification for creating separate programs associated with forensic and non-forensic admissions. Legal status upon admission is not a clinical marker that indicates that a different type of care should be rendered. However, the new program components proposed in Part IV of this plan need more capacity than currently exists to manage dangerous behavior safely, and to separate people who are behaving dangerously from the general inpatient program. This applies to all types of admission statuses and it is one of the reasons that a new level of care is proposed, namely the psychiatric inpatient intensive care unit.

Community Services

Designated Agencies

DAs, commonly known as community mental health centers, are responsible for ensuring that needed services are available through local planning, service coordination, and monitoring outcomes within their region. The DAs must provide services directly or contract with other providers or individuals to deliver supports and services consistent with available funding, the state and local system of care plans, outcome requirements, and state and federal law, policies

[44] This is the most recent year for which key aspects of the data can be summarized, such as length of stay, in that the most recent year has admissions that have not yet been discharged.

[45] Some people had more than one observation admission during the year, and some also had more than one charge associated with each admission. Thus the numbers of charges adds up to more than the number of people and the number of admissions is also more than the number of people.A felony is a crime punishable by more than two years imprisonment. Examples include murder, aggravated assault on a police officer, sexual assault on a minor, and kidnapping. A misdemeanor is a crime punishable by two years imprisonment or less. Examples include disorderly conduct, simple assault, writing a bad check, and negligent operation of a vehicle.

[46] Of the 16 people admitted with a violent felony, one received emergency involuntary intervention.

and guidelines. Annually, DAs provide mental health, substance abuse and emergency services to more than 17,500 adults and over 10,000 children.[47]

A study of the sustainability of the DA system was completed in November of 2004 by the Pacific Health Policy Group. Among the report's chief findings are these contained in its executive summary: *"The Designated Agencies have, by and large, been successful in operating efficient, community-based systems for a wide range of behavioral and developmental services. The non-competitive nature of the DA system and the bottom-line regional responsibilities delegated to the Designated Agencies has fostered the development of a system of care that is highly effective in meeting the unique needs of Vermont communities."*[48]

The DA system, administered by DMH, is further discussed in Appendix 5.

In response to the findings of this study, the secretary has recommended that the DAs increase resources to their adult outpatient, substance abuse and emergency programs. It is likely the general erosion in availability of outpatient services increases the demand for more costly emergency and hospital-based care, but there are no data to prove this conclusively.

A more comprehensive analysis of outpatient mental health services in Vermont is underway. Multiple providers serve the public and private mental health system in Vermont, including DAs, private psychologists and psychiatrists, private mental health clinicians, substance abuse providers, school based counselors, and primary care medical providers. Coordination of services across providers, specialties and settings is required to assure the mental health needs of all Vermonters are being met.

Transportation

DMH is usually responsible for paying for transporting individuals who are being admitted to a hospital for involuntary inpatient treatment or evaluation. The Agency of Human Services contracts with Vermont sheriffs' departments to provide this service. In most instances the vehicle used is a sheriff's cruiser and the patients are shackled during the drive, even if they are fully cooperative with being transported. We are concerned that transportation of mentally ill patients in restraints by uniformed deputies in marked cruisers is, in the words of one legislator, "anti-therapeutic, traumatic, and unnecessarily coercive to achieve the objectives of patient and community safety."[49] The Legislature recently passed legislation requiring a transportation system that prevents trauma, respects privacy, and uses the least restrictive methods consistent with safety.

DMH has recommended:

[47] FY2004 Statistical Report; Table 1-1 Number of Clients Served, Agency of Human Services.
[48] VT's Designated Agency System for Mental Health, Substance Abuse and Developmental Services System Evaluation & Five-Year Projection of Service Demand and Analysis, Pacific Health Policy Group Nov. 1, 2004.
[49] Letter from Representative Tom Koch to Department of Developmental & Mental Health Services, May 30, 2003, requesting a report on issues of involuntary transportation.

- using a risk assessment procedure and criteria to match patient needs for security and medical oversight with appropriate transport methods,
- using restraints only when necessary for safety,
- training law enforcement and emergency medical staff, and developing a civilian (neither law enforcement nor ambulance) transport system.

In addition to concerns about finding less-coercive forms of transportation for involuntary clients, advisory group members expressed strong concerns about the difficulty in arranging safe transportation for individuals in crisis who accept voluntary treatment in crisis stabilization programs and inpatient programs.

If the current involuntary care system is further decentralized as proposed in Part IV of this plan, the transportation system will also need to be further developed.

- A dispersed, community-based system probably would require more transportation capacity; a greater number of service sites (either hospital or residential) would increase the number of trips.
- A system with certain centrally located, specialized services (for example, non-hospital crisis services) might require more, and longer trips.
- A system that integrates all services into a statewide system may require additional transportation as utilization is increasingly driven by a managed approach that accounts for statewide needs and capacities.
- A transportation system for people being referred on a voluntary status is also needed to assure timely and dependable access to care.

Housing

Housing is one of the more important contributions to recovery. Vermont's communities are facing a shortage of affordable housing and, for people living with mental illness, the housing shortage has two primary aspects. The first is a shortage of supportive housing services, and the second is the wide gap between consumers' incomes and the market rates for rental housing. In Vermont, it takes 91 percent of a monthly Supplemental Security Income (SSI) check to rent a one-bedroom apartment.[50] Statewide, the CRT program provides 135 residential group treatment beds and provides linked supportive services to an additional 123 subsidized beds. Even so, a recent survey of CRT programs showed that clients typically wait up to 24 months for an apartment, that there were 79 CRT clients waiting for affordable housing at the time of the study, and that another 50 were waiting for some type of staffed or supported housing. See Appendices 6 and 7 for the inventory of residential resources and for the survey.

Several strategies exist to help address the housing needs of CRT consumers. The development of new housing through work with not-for-profit housing developers, the federal Department of Housing and Urban Development, and the Vermont Housing and Conservation Trust fund; a rental assistance program; support for outreach and engagement supports; and housing start-up subsidies for people who are homeless, have mental illness, and who are not otherwise connected with the services system.

[50] Priced Out in 2002: Technical Assistance Collaborative Inc. Boston, MA.

The VSH Futures Advisory Committee strongly recommends increasing the resources available to assist clients to have more choices for safe, supportive, affordable housing. There are two general approaches that can be used to increase available housing: rental subsidies or some type of staffed, supportive housing program.

The current rental assistance program for CRT clients (called the housing contingency fund) could be expanded. This fund is used to provide individuals with rental assistance and also to help cover the costs of starting up an apartment (deposits, utility hook up, furnishings etc). The housing contingency fund could be expanded from its current allocation[51]. Rental assistance is one of the fastest and most direct ways to help people gain access to and keep housing.

Alternatively, some sort of staffed or supported residential program could be created. One option would be to apply to create a third HUD Safe Haven Program in Vermont[52]. Safe Haven programs are group residences for individuals who are homeless and have mental illness. They are transitional programs (residents may stay for up to two years) and the goal of these programs is to assist people to transition into permanent housing. Alternatively, with leveraging funds, Vermont could apply for other types of HUD- sponsored supportive housing (Shelter Plus Care, Transitional Housing, or Permanent Housing for the Homeless). The process to apply for these funds requires that both a local "housing continuum of care"[53] and the state-level continuum agree to rank the proposed project as priority number 1. Funding for new and existing projects is subject to how well Vermont's overall continuum of care application is developed and scored.

Yet another option would be to develop a residential treatment program using the same financing options through the 1115 Medicaid Waiver described in Part VI of this plan.

Two new types of residential treatment programs proposed in Part IV, a sub-acute rehabilitation capacity and a secure residential facility, are expected to speed access of current inpatients at VSH to more clinically appropriate and community-based care.

Ultimately, increasing consumers' incomes through employment is also an important way to help address the housing affordability gap. A sustained project to expand access to evidence-based supported employment services for CRT clients is already underway.

[51] The resources dedicated to the Housing Contingency Fund have never been increased since its inception in the late 1980's.

[52] Vermont currently has two HUD Safe Haven programs, one in Burlington and one in Randolph. The program in Randolph is unique nationally in that it is operated by a blend of peer and professional staff and has a strong recovery focus.

[53] The "Continuum of Care" process is a HUD- mandated multi- stakeholder planning process in which local areas and the state establish priorities for housing development based on a needs assessment and availability of funds for new projects. Because the HUD programs mentioned above must be renewed on one to three year cycles, funds to support existing projects may compete with funding for new projects. Therefore, the priority ranking of the local and state continuum is critical. Each year, there are "bonus" funds that can be applied for on behalf of new projects, if they are ranked as priority number one.

Peer Services

Vermont Psychiatric Survivors, an independent peer-run organization, provides supportive services, advocacy, and education to consumers state-wide under contract with DMH. These services include technical assistance and funding for local self-help support groups statewide; the operation of a toll free information, referral, and support telephone line; the staffing and operations of the Safe Haven residential program in Randolph (in collaboration with the Clara Martin Center and NAMI-VT); outreach workers providing individual assistance and advocacy services; the quarterly publication of the Counterpoint newspaper on news, arts, and perspectives important to the peer community; and the Recovery Education Project (see below). In addition, DMH supports a peer-run drop-in center in Montpelier.

The Recovery Education Project is psycho-education program that uses an established course curriculum. It is taught by peers and providers and is designed to help consumers develop personal skills to cope with symptoms of mental illness, to learn how to more effectively advocate for health and mental health care needs, to better use teams of health care providers, to develop more supportive natural networks, and to develop crisis plans. The program is highly valued by peers and providers statewide and is consistent with the developing evidence-based practices on psycho-education and peer support.

There is a necessity for developing more peer services and services with blended peer and professional staffing patterns. The importance of peer-support and meaningful peer involvement in the formal service system may be especially critical to promoting resilience and recovery.

Individuals who have had significant histories of involuntary treatment at VSH and are under outpatient commitment orders are among the most at risk of involuntary inpatient treatment of any Vermonters and are often in need of the most formal services and peer supports.

A pilot program called *Community Links* focuses on this at risk population. *Links* matches trained peers to individuals at VSH and provides them with support using Recovery Education approaches and materials. This is the first peer initiative using an evidence-based psycho-educational approach targeted to individuals who have been repeatedly hospitalized at VSH. Preliminary findings of the pilot are encouraging.

Legal Services

Prior to the use of DAs, virtually all involuntary hospitalization in Vermont occurred at VSH. During the past decade, Vermont has begun to decentralize where involuntary hospitalization occurs. However, the vast majority of commitment hearings still occur in Waterbury, for patients at VSH. The attorneys for the State (assistant attorneys general who work with DMV) and for the patients (lawyers with the Mental Health Law Project of Vermont Legal Aid) remain located in Waterbury. The advent of decentralized involuntary hospitalization has taxed the ability of lawyers for both sides to provide adequate representation, and further decentralization would require increased legal resources. Vermont Legal Aid will need to visit clients at all DHs and the attorneys for both sides will need to travel to hearings and to the hospitals to meet with medical staff to prepare for hearings.

Part IV - The Plan: Proposed Capacities

This section details the strategy for replacing the services currently provided by the Vermont State Hospital, developed within the context of long-range planning for a comprehensive continuum of care for mental health services. All programs will be expected to demonstrate commitment to trauma informed services. This includes screening patients for trauma histories and using best practice guidelines for working with people who have experienced trauma. All programs will be expected to actively involve peers and patients in developing program policies and service procedures.

This plan continues the process of "regionalizing" the system of care to local communities and contracted partners begun by the state mental health authority with the first wave of Deinstitutionalization in the 1950's.

Under the plan proposed here, the current capacity of 54 beds at VSH would be preserved, but the beds would be more appropriately distributed among programs offering different levels of care and greater local access to many services. In addition, to strengthen the system's capacity to offer alternatives to hospitalization, 10 new diversion beds would be added to the system's current 19 diversion beds, for a total of 29 diversion beds; these would be distributed around the state and both current and new diversion beds would be designated for multiple levels of care, depending upon the needs of the individuals assigned to them.

The infrastructure needed to realize this plan is also described.

Hospital Based Care

As with other aspects of medical care, there are gradations in hospital levels of care related to intensity of service needed (analogous to observation units, trauma centers, and intensive care units in general hospitals), security of setting necessary to protect individuals from self-harm or harm to others (analogous to burn units and isolation units for infectious diseases), and length of stay (average of 7–9 days and a range of 1-94 days). We propose three levels of psychiatric inpatient care be available to Vermonters: general, specialized and intensive.

General Psychiatric Units

Vermonters seeking voluntary treatment for psychiatric illness currently have fairly good regional access to hospitals, with the exception of the Northeast Kingdom and Northwestern Vermont.[54] Designated hospital (DH) units that have expanded their mission to include the provision of involuntary care have accomplished this by enhancing the security of their units by instituting means such as locking doors to the unit, implementing search and risk assessment policies on admission and so forth. Since 1992, the utilization of the DHs has shifted the proportion of patients hospitalized at VSH on emergency examination status from 100% being admitted to VSH to 28% of total EE's admitted to VSH. However, all hospitals report having

[54] The Northeast Kingdom includes Essex, Orleans and Caledonia counties. Northwestern includes Franklin and Grand Isle counties.

reached their maximum ability to serve acute involuntary patients within their existing physical structures, staffing patterns and length of stay pressures.

Overall, the capacity in the designated hospitals for involuntary treatment has not significantly impacted the bed day replacement needs for VSH, which are primarily driven by the average daily census of long term patients.

We **do not recommend an increase in the statewide number of general hospital units** at this time. As Table 3 shows, there is significant unused bed capacity[55] in Designated Hospitals and the new capacities being developed in the community may further reduce the need for inpatient care. The completion of the Health Resource Allocation Plan in connection with ACT 53 may alter this recommendation. Mental health issues and substance abuse have been identified as the top two needs by many communities as part of the hospital community needs assessment, pursuant to Act 53.

Table 3: Current Psychiatric Inpatient Services for Adults in Vermont

Hospital and Location	No. Psychiatric Beds	Average Daily Census Calendar 2002	Average Unused Capacity
Fletcher Allen Health Care, Burlington	28 (12 doubles, 4 singles)	19.3	8 beds
Central Vermont Medical Center, Berlin	14 (6 doubles, 2 singles)	11.0	3 beds
Windham Center (Springfield Hospital), Bellows Falls	19 (9 doubles 1 single)	11.4	7 beds
Rutland Regional Medical Center, Rutland	19 (7 doubles, 5 singles)	12.7	7 beds
Retreat Healthcare, Brattleboro	46 (4 doubles, 38 singles)	26.6	20 beds
Vermont State Hospital	54 (6 doubles, 42 singles	48[56]	6 beds

Specialized Inpatient Units (SIPs)

At present, only Vermont State Hospital is able to meet the needs of individuals who require specialized inpatient care. These individuals are admitted directly from the community, referred by the courts for observation, or are transferred from the designated hospitals. As detailed above, they share the following characteristics:

[55] The full use of existing bed capacity depends on many variables, including the availability of staff, and the gender distribution of patients in units with double occupancy rooms.

[56] Average daily census at VSH is 55.9 if including patients on pre-placement visit; the number in Table 2 refers to the in-house census at VSH.

- almost exclusively admitted on an involuntary basis,
- refuse medication and often other forms of treatment,
- likely have diagnoses of schizophrenia or other psychotic disorder,
- have, on average, lengths of stay greater than 30 days.[57]

The characteristics of a specialized inpatient unit include both staffing and architectural attributes. The staffing pattern include:

- Higher RN to patient ratios (one nurse to four patients) than may be found in designated hospital psychiatric units.
- Psychiatrically trained direct care staff (registered nurses and psychiatric technicians or mental health workers) whose core competencies include:
    - assessing and reducing of suicide risk
    - assessing and reducing risk of aggression
    - non-aggressive, humane interventions in the management of violent behavior
    - participation in the creation of individualized plans of care that is trauma-informed and recovery-centered
    - preventing seclusion and restraint.
    - using and teaching recovery methods, including the creation of individualized crisis plans
    - motivational interviewing techniques
    - implementing behavioral plans

- Psychiatrists with special expertise in forensics, in the care of persons with serious mental illness, in substance abuse, in recovery methods, and in trauma care.

In addition, specialized inpatient level of care must have easy access to general medical care. Finally, SIP programs will have ready access to specialty consultations from psychology, neuropsychiatry, and other disciplines.

The physical characteristics of a specialized inpatient service must be optimized for safety, include single rooms, adequate space to allow for physical activity and exercise, and quiet areas to facilitate voluntary regaining of control of one's behavior (commonly known as places of quiet or time-out rooms)

Intensive care units (ICU). This more enhanced version of a specialized unit provides acute, stabilizing care and allows for maximum containment of patients most at risk of violence to self and others. This physical capacity does not currently exist at VSH; individuals with this level of need are managed by increased staffing (1:1 or 2:1 staff to patient ratios) and at present are more

[57] In the context of the diagnostic categories, patients with thought disorders have the longest average stay when at VSH. The hospital overall average in 2003 was for 19 percent of patients to be discharged within a week, 39 percent within two weeks, and 80 percent by the end of three months. Those with schizophrenia and other psychoses were discharged at a rate of only 9 percent within one week and 20 percent within two weeks (half the average rate). At the end of three months, 29 percent were still hospitalized. This was highest percentage of all categories, with the next closest at 19 percent.

likely to require emergency involuntary interventions such as seclusion and restraint to prevent harm to self and others.

The main distinguishing features of the ICU would be: size, configuration of physical space, monitoring capacity, higher registered nurse-to-patient ratios, and a staff with enhanced skill set and experience.

In order to be responsive to the needed patients who have experienced trauma, the SIP and ICU programs will be required to implement the core elements of a trauma informed treatment system including a continuous review of the programs' policies and practices to assure that these do not replicate trauma dynamics for patients and staff.[58]

As the ICU capacity does not yet exist, it is difficult to estimate the total number of beds statewide that should be developed. However, based on an analysis of the current census five year trend[59] (including variance to help predict surge capacity), regional utilization patterns, national averages, projected population, the small but critical subpopulation currently incarcerated, and reasons for transfer from general units to VSH, we recommend that **32** (of the 54 beds at VSH) beds be maintained in the system of inpatient care and that **12** of these be developed as intensive care beds.

It is important to stress that all partners providing inpatient care will be expected to meet the highest performance standards of care appropriate to each level of care.

These **32 beds** could all be located in one location, or in as many as three locations. All configurations presented are clinically sound; to the extent financially possible, preference would be given to further decentralizing SIP and ICU care to help further the goal of treating individuals as close to home as possible. Final decisions regarding locations and operators would depend up the outcome of an RFP process. These beds could be operated under the license of the host hospital, however a 16 bed configuration could be run by DMH if necessary. Possible configurations, based on current capacities and on expressions of interest in response to the recent RFI are as follows:

a) **Locate all thirty-two (32) beds at FAHC, including 12 ICU beds.** Establishing beds in Chittenden County in partnership with Fletcher Allen achieves the following goals: it matches the geographic distribution of current utilization and population projections; provides a partnership with academic institution; affords integration with a general medical

[58] Source: Self Assessment and Planning Protocol: Community Connections, Fallot and Harris, 2004.

[59] In the most recent year (calendar 2002) for which we have data from all hospitals just over three thousand (3,116) adult Vermonters were admitted to a psychiatric inpatient program. Appendix 9 and 10 shows the twelve year trend of episodes of hospitalization, the number of people hospitalized and the number of patient days. The number of episodes of hospitalization overall show small increases annually, however there is significant variation in the episodes per population by county. Bennington, Orange, Rutland, Washington, Windham, and Windsor counties all show significantly higher rates of hospitalization. Appendix 8 shows the unduplicated count of Vermont Adults hospitalized between 1992- 2002 and their county of residence. Appendix 9 shows the episodes of hospitalization per 100,000 population by hospital, county and over time. For calendar 2002, fewer than one thousand Vermonters (960) were hospitalized per 100,000 and of those hospitalizations; the most were at general hospitals. Windham Windsor and Rutland counties respectively had the highest rates of hospitalization.

hospital; and would best serve that part of the state with the largest population. In addition, this scenarios may offer economies of scale.

b) **Locate thirty-two (32) beds at FAHC, including eight ICU beds. Integrate four (4) additional ICU beds at Rutland Regional Medical Center or at Springfield Hospital.**[60] This scenario helps enhance the capacity of more programs to serve people closer to home.

c) **Locate sixteen (16) beds at FAHC, including four ICU beds. Locate a second sixteen (16) bed program on the campus of a general hospital, including 4 ICU beds.**[61] **Integrate four (4) additional ICU beds at Springfield Hospital or Rutland Regional Medical Center.** This scenario further decentralizes care and increases the capacities of multiple programs.

For an analysis of the number of psychiatric beds that each of Vermont's hospitals could add without becoming an IMD, see Appendix 10.

Non-Hospital Based Care

Sub-acute care (16 beds, relocated from VSH)

Sixteen beds would be assigned to one or more sub-acute care programs for individuals who need intensive rehabilitation, but do not need to be hospitalized. For purposes of illustration, these beds are accounted for here as if they were in a single location, but it could be done in two localities. This program would be run by one or more DAs, hospitals, and/or other contractors[62] and would be run by DMH only as a last resort. The beds could be located anywhere in the state, although locations near population centers and/or interstate highways would be preferable. Final decisions regarding locations and operators would depend up the outcome of an RFP process. A more detailed description of the subacute rehabilitation program follows.

As envisioned, this represents a new level of rehabilitation programming in Vermont's mental health service system. The capacity that would be provided by this component would be somewhat like that of physical rehabilitation programs in which individuals adjusting to catastrophic illness or injury receive intensive services to consolidate the gains made in inpatient care, to develop new skills and to regain lost capacities for making informed decisions and in managing the affairs of one's life.

No national models have been identified that specifically provide this level of rehabilitation. These programs would offer best practices related to recovery, cognitive rehabilitation, occupational therapy leading to supported employment, treatment for substance abuse, peer support through blended peer staffing, and intensive treatment for issues related to trauma.

[60] The addition of four ICU beds at either of these hospitals would allow for a reduction at FAHC to 28 beds or allow an expansion of overall capacity in the system.
[61] Brattleboro Retreat, which is exploring a number of options to address its own IMD issue, has also expressed interest in developing this bed capacity.
[62] As part of the terms of a contract to provide sub-acute services, a provider new to the system might become a DA.

There are currently 16 individuals either at Vermont State Hospital (the majority are on Brooks Rehab) or on extended pre-placement visits whose needs would be better served by such a program. All are involuntarily committed to VSH or on orders of non-hospitalization. It is our belief that a more decentralized, community-based, and recovery oriented rehabilitation approach may mitigate the need for involuntary treatment and thus support our goal of increasing voluntary treatment in our system.

The needed 16 to 20-bed capacity would optimally be provided in two or more decentralized program sites. The physical design of these units and intersection with the general community in which they are located are considered integral to enhancing capacity and self-determination. Apartment settings with shared common areas, modular units organized into a small community within a community, or other therapeutic community residences might be considered options.

These program(s) would serve as state-wide rather than catchment area resources and would be expected to operate in collaboration with inpatient treatment and ongoing community care.

Secure residential (6 beds, relocated from VSH)

Six beds would be assigned to a secure residential program for individuals who are considered a danger to society and have been assigned to the custody of the commissioner, but who are not in need of hospital or sub-acute level care. For purposes of illustration, these beds are accounted for here as if they were in a single location, but that need not be the case. The secure residential program would probably be run by one or more DAs or other contractors, but could be run by DMH The beds could be located anywhere in the state, although a central location with interstate highway access would be preferable. If the State were to run the program, it might be located in a renovated portion of the current VSH physical plant in Waterbury. Final decisions regarding location(s) and operator(s) would depend up the outcome of an RFP process. A more detailed description of the secure residential facility follows.

Among the patients served at Vermont State Hospital there is a small subgroup of individuals who in the past have committed (or are alleged to have committed) dangerous acts in the community. These patients may spend years at the VSH, respond well to treatment, and become stable vis a vis their psychiatric and/or other conditions[63] which caused them to be committed to the care and custody of the Health Commissioner. This small subgroup is comprised of four to eight individuals at any given time, and while their numbers are small, because they often stay at the hospital for years, this group uses a significant proportion of the available bed days, or treatment capacity at VSH. From a clinical perspective, their inpatient treatment is complete and they are no longer in need of hospital care. From a legal perspective they are committed year after year to the Department's care and custody. From a social perspective, they may be perceived as posing a public safety threat that must be addressed. As long as VSH was viewed as an "institution" Vermonters were content to remand such individuals to VSH indefinitely. In the current context, in which VSH must function as a hospital providing active treatment to all patients, it is untenable to have a group of clinically stable individuals use the most intensive

[63] In addition to psychotic and affective disorders, patients in this small sub group may also have brain injuries and developmental disabilities.

treatment resources available to the state. Therefore, the Futures Plan proposes to create a secure, alternative setting for this small sub group of patients.

Proposed is a residential program that offers ongoing mental health treatment and intensive levels of supervision in a secure setting. The mental health treatment component will be individually determined but usually will include provision and monitoring of psychiatric medications, individual counseling to assist with adjustment to the residential setting and transition from the hospital, and rehabilitation services. The rehabilitation services will focus on productive community living including work. In addition, treatment for substance abuse, cognitive and/or behavioral interventions and social skills training will be available as needed. The core, unique aspect of the mental health treatment in this program will be the capacity to monitor each residents' engagement in and cooperation with treatment, to recognize if the resident is disengaging from treatment and to respond robustly to re-engage in treatment or to rapidly return to an inpatient level of care.

Supervision will be provided on a 24-hour, seven day a week basis by qualified mental health staff. Protocols with public safety officials will be developed to insure a rapid, law enforcement response to any resident who is on an unauthorized absence from the residence or work site. Initially residents will be supervised at all times, but over time, we expect that some individuals may "graduate" to reduced levels of supervision and increased levels of community privileges based on a developing track record of safe and responsible behavior. The program will have ten full time equivalent staff and will use existing community resources to assist with vocational and support services.

The facility will have security features. It will be locked during the evening and overnight hours, and will have a buzzer system that notifies staff if a resident leaves or someone from the outside enters. In some instances, rooms will be equipped with video surveillance to augment staffs' ability to track the presence of residents.

Residents of this facility will be on "Orders of Non-Hospitalization" and will need to voluntarily consent to participate in the program.

In order to be responsive to the needs of all people, and especially those individuals with trauma histories, all of the proposed programs will need to develop strong protocols to support informed consent of clients and to clearly convey information about what will be done, by whom, and under what circumstances in each of disposition options being explored with the client. This will help facilitate client empowerment and autonomy and help to prevent unnecessary re-traumatization.

<u>Diversion (10 beds, new)</u>

10 beds are planned to augment 19 existing diversion beds in programs run by DAs around the state. Currently the diversion beds are used for crisis stabilization and hospital stepdown. Under this plan, all diversion beds would be available for and adaptable to four types of care:

a. **Triage and observation care (24 hours):** This new program would provide a brief safe haven for individuals who now are likely to be kept in hospital emergency departments pending referral. Individuals would remain in triage and observation until they had been assessed by an appropriately trained professional and either released or moved to another level of care.

b. **Crisis stabilization care (24-48 hours):** This program currently offers care for up to two days, after which individuals typically either are stable enough to be released or are transferred to hospital care. Under this plan, individuals who have not stabilized might be transferred to a hospital if necessary, but most could be expected to qualify for a new hospital alternative level of care instead.

c. **Hospital alternative care (3-7 days):** This program would focus on delivering professional care and peer support in a home-like, non-institutional setting located as close to the individual's home community as possible.

d. **Hospital stepdown care (24-72 hours):** This program would continue to offer care for individuals transitioning to outpatient care. Persons in stepdown beds typically begin the program upon release from a hospital and are discharged at the end of their one- or two-day stay.

These 10 emergency/triage beds will be associated with existing inpatient and/or community programs that already operate 24-7 and have access to mental health and medical services. The programs are designed to be flexible and to utilize blended peer and staff models. These will offer more immediate respite to the individual and his/her involved network, and will provide time to understand and address how to resolve the current crisis. For additional information on the current system (See Appendix 11).

To ensure appropriate utilization of these beds, this plan calls for the development of a care management system.

Care Management System

In Vermont's health care system, no patient is turned away from a hospital because their illness is "too acute," and, in turn, no one hospital is expected to provide all services, all the time. Instead, through a system of internal management, clear definition and expectations for each hospital's role, and triage conventions, our hospitals collectively assure that all Vermonters in need of inpatient care receive that care. This network of collaborating partners to be implemented in Vermont for acute psychiatric care is similar to the collaboration that occurs in general health care among hospitals, rehabilitation services and outpatient services.

The yet-to-be-selected participating partners will develop a common, standardized definition for each of these levels of care. Each program will be understood to fulfill a particular role in the system. Pending legislative approval of this approach, a workgroup comprised of consumers, clinicians and administrators will be convened to develop a single set of admission, continued stay, and discharge criteria for each type of program. In other words, a common standard will be

developed to determine admission to any of the 126 psychiatric inpatient beds, or the 19 crisis stabilization/inpatient diversion beds. Vermonters needing acute care will have access to the whole continuum of services and the participating partners will agree to collaborate to ensure that the available bed capacity is adequate to meet the needs of clients.

Creating an Interdependent System of Inpatient Care

DHs are indispensable in providing urgent specialty psychiatric care within the public mental health system and further the goal of providing each individual with quality treatment as close to home as possible. Currently, they function cooperatively but not interdependently. The following changes are necessary to support transformation to an interdependent system:

- Explicit standardized admission criteria for general, specialized and intensive levels of care need to be developed and adopted by all DH's.
- Best practice standards and clinical systems must be adopted by all DHs.
- A no-rejection policy must be adopted by each DH for individuals who meet criteria for involuntary *general* inpatient care from *within the area* served by that hospital.
- A no-rejection policy must be adopted by all DHs who provide *specialized* and/or *intensive* treatment statewide.
- A centralized information system must be developed and implemented to provide clinicians in the field with instant information about available resources at the time a need for hospital diversion has been determined. Clinicians should be able to complete a simple internet transaction or make a single call and enable patients to move quickly to an appropriate site for treatment without long waits in the emergency rooms.
- An information management system must be implemented in which data collection is streamlined, focused, and made consistent across all designated agencies for comparable service lines. This system must be implemented in such a way that performance and cost measures are relevant and comparable across the system to achieve consistency is achieved in the evaluation of therapeutic thresholds, and in the design and cost of service plans for individuals with equivalent levels of need across the state.

The Qualified Mental Health Professionals (QMHPs) will authorize entry to the network. This will necessitate a change in the role of the QMHP from the more narrow screening and gate-keeping function to include a more robust assessment function in which the QMHP will recommend the level of care and program that is most appropriate to meet an individual's needs, based on the clinical presentation, and the use of standardized instruments, trauma-informed best practices, availability of peer and staff resources, and the available resources in the person's personal network. Screening protocols for trauma and substance abuse in addition to mental illnesses will be universally implemented. This will necessitate and the development of clear performance standards and an enhancement in the level of expertise, training and oversight of this key position

In order to handle their expanded role, the QMHPs will need the following resources and capacities:

- statewide access to a continuum of acute care services (crisis stabilization/inpatient diversion beds, psychiatric inpatient, specialized inpatient, and psychiatric ICU beds).
- an information system capable of tracking utilization and availability of beds
- availability of safe, timely and appropriate transportation of individuals between programs.

In addition, in order to provide appropriate services to all individuals – but especially those who have experienced trauma, the QMHPs need to be able to assure physical and emotional safety (see Triage Capacity proposed below) and to be able to offer a range of options that maximizes choice and control for individuals being served.

The use of standardized placement criteria (admission, continued stay, and discharge) will be monitored by a small team of VDH staff. Their role will resemble the current VSH acute care team in that they will facilitate resolution of systems issues, assure connections with ongoing care, and ensure that the various system components and programs work together as needed. In addition, the role will expand to include working with the partnering programs on proactively managing bed use to ensure that service capacity is available when needed. Census management protocols will be developed with each participating partner and these would be implemented by the local programs with the assistance of the acute care team.

This system will also require that an appropriately clinically empowered systems administrator be available at all times (24/7) to consult with QMHPs regarding placement recommendations and to facilitate access to needed levels of care. The recommendation of this plan is that the administrator role be rotated among all the participating partners. For instance, on a quarterly basis, the role will shift to a different provider, ensuring that each gains experience in the triage operations of the whole network.

As this process further evolves several infrastructural components will need to be in place. These are:

- *Client level service encounter data system* with timely reporting and appropriate HIPPA compliance by all service providers. In turn, the Mental Health Authority needs adequate information technology (IT) capability to assure data integrity, develop regular and ad hoc management reports, and to create new programming as needed.
- *Business Office* and *Financial Reports* to oversee the fiscal health of the service system, to account for the public resources invested, and to investigate and report on the real costs of providing services
- *Legal Service* to insure that clients' rights are protected, that the custodial role of the state is appropriately carried out, and to insure that clear and enforceable contracts with service providing partners are developed and maintained.
- *Clinical Management* to design standardized protocols governing the flow of patients through the system, to consult in complex issues of patient care, and to evaluate the quality of the services being rendered by participating partners.
- *Program Development and Evaluation* to guide program implementation, to evaluate the effectiveness of existing programs and to identify new service approaches for adaptation and use in Vermont

- *Quality Management Quality Improvement system* To identify clear outcomes for each component of the services system, to measure progress to those outcomes, to benchmark outstanding results, to implement plans of improvement and correction as needed, and to design new approaches and systems to improve clients outcomes

Challenges:

There are many challenges in attempting to realize this vision of decentralized, community-based care. Central among these is the need to ensure that patients have access to high quality state of the art care, access to research initiatives, receive adequate and appropriate information about their rights, meaningful access to legal representation, and full protection and enforcement of advance directives. The legislative intent of Act 114 is explicit in its unqualified support for protected decision making when competent: *"It is the intention of the general assembly to recognize the right of a legally competent person to determine whether or not to accept medical treatment..."* 18 V.S.A. § 7629. Not only are all physicians and health care providers bound to follow the directives of a designated agent; the health care provider is required to *"develop systems to ensure that a patient's advance directive is promptly available when the patient is to receive services from the provider."* (Act 162, 2004)

We propose to ensure quality and safeguard rights through:

- Appropriate credentialing
- Utilization of best practices
- Academic affiliation
- Consumer and family involvement in systems planning and design

- creation of a treatment options work group to further develop recommendations for both community and hospital treatment alternatives.

- consistent training and oversight at all sites for involuntary procedures, whether involving involuntary, voluntary, general hospital patients or corrections inmates for whom added involuntary procedures related to mental illness are used.

- implementation of the statutory revisions directing that less traumatic forms of involuntary transport be used when consistent with safety and that the ability to access alternatives that are developed regarding inter-hospital transfers will be enhanced by the planning time permitted by use of pre-admission emergency triage beds.

- implementation of improved monitoring of involuntary interventions, including close review of actual "best practice" facilities and equipment for safety in restraint and seclusion.

Part V: Futures Plan Projected Costs, Finance Strategy, and Implementation Phasing

The costing approach to each of the proposed capacities is based on the DMH's current experience operating inpatient services and contracting for an array of community services. For those capacities that are entirely new (the inpatient ICU service, the sub-acute rehabilitation program, the peer service and the secure residential program) a staffing model was designed and basic operational assumptions were made. While the approach is sound, the assumptions and staffing models may not fully reflect actual program development and operation. For instance, in the case of the inpatient services, the costs of operating an independently licensed, stand-alone hospital of 16 beds may be quite different from that of a 16 be program in conjunction with an existing hospital. Following is a description of the basic approach employed to develop the cost estimates.

Cost Models

Inpatient Services, Sub Acute Rehabilitation, and Secure Residential Facility

The cost estimates for the inpatient services are based on two distinct programs: specialized inpatient (SIP) and intensive care (ICU). A staff to bed (patient) ratio for nursing and psychiatric technicians was created to facilitate various configurations of program size and relative number of ICU beds. In addition, staffing models for other direct care disciplines (psychiatry, social work, psychology, activity / occupational therapists) were developed based on program size. For instance, the 32 bed configuration calls for 1.5 FTE psychologists while the 16 bed configuration calls for 1 FTE. Similarly, other support staff (cooks, housekeepers, senior leadership, pharmacist, secretarial, business, and patient relations) were assigned based on the number of beds in the program.

All staffing positions are based on the State of Vermont pay grades, including a market factor adjustment for nursing salaries and shift differentials. The step-level was calculated using the current staffing array at VSH in terms of length of time in position. This results in a representative spread of seniority levels in all areas except nursing staff[64]. In addition, a leave replacement formula (for sick time, annual leave, workers compensation, military service etc.) was applied to calculate the number of FTE needed to staff three shifts per day, seven days per week. (See Appendix 12.)

Operating expenses (supplies, furniture, food, medications, equipment leasing etc) are based on the current costs at the Vermont State Hospital. The cost assumptions for space (square footage for patient rooms, activity and program space, administrative offices, kitchen etc) are based on the current VSH square footage for these functions scaled to program size (e.g. number of beds).[65] Estimates for annual physical plant and equipment depreciation were assigned based on

[64] The Nursing staff at VSH reflect a disproportionate number of new hires. Even so, we used the current spread at VSH in this cost modeling.

[65] The current square footage at VSH is admittedly small for the functions it performs.

the estimated costs of the facilities amortized over thirty years. In addition, an estimate for "fee for space" was included based on the actual rates for the current VSH structure.[66]

The nurse to patient ratio for the *specialized inpatient program* is 1 nurse to every four patients (1:4)[67]. The ratio for psychiatric technicians is 1:8[68]. The nurse to patient ratio for the *intensive care unit* is one nurse for every two patients (1:2) and the ratio for psychiatric technicians is 1:4.

The *sub acute rehabilitation program* cost estimates use the same salary and leave calculations as for inpatient services; however the staffing pattern is different. For this program, a nurse to resident ratio of 1:16 is applied, and the staff to resident ratio for psychiatric technicians is 1:4. In addition, the staffing calls for 1 FTE social worker and 5 FTE activity/occupational therapists.

The *secure residential treatment facility* also uses the same salary and leave calculations; however the staffing pattern calls for two psychiatric technicians per shift, one FTE nurse and occupational therapist for the program, a program director, and a part time social worker. The cost model for the secure residential treatment program assumes that all other professional services are provided by existing community mental health and health care services. (See Appendix 13).

Additional Non-Hospital Capacities

The Futures plan proposes several other infrastructural capacities and services. The approach used to develop estimated costs for these is described below.

If the thirty two (32) proposed inpatient beds are sited at more than one location, the costs to provide *legal representation* for the involuntary patients may rise. VT Legal Aid estimates that it needs to hire an additional two attorneys to provide legal representation. Similarly, the Vermont Attorney General's office estimates that it would need an additional two attorneys. The estimated cost of salary and fringe to hire four attorneys (two for the state, and two for the Mental Health Law Project of Vermont Legal Aid) is $300,000. The attorneys for each side manage the constant flow of cases to family courts. Legal representatives must prepare cases for hospitalization hearings, involuntary medication hearings, and hearings for orders of non-hospitalization. The preparation for these involves meeting with the patient and consulting with the treatment teams at each hospital. Each side negotiates stipulations and, in about twenty percent of the cases, a hearing is required in the family court located closest to where the patient resides. In addition, the state attorneys consult with the experts providing forensic evaluations, screeners, and the courts in an ongoing basis. These estimates are being revised at this time.

[66] This fee for space calculation is probably lower for the current VSH than it would be in a new or newly renovated facility.

[67] The current nurse to patient ratio at VSH is 1:10 patients. By comparison, the Fletcher Allen Health Care union contract requires a nurse to patient ratio of 1:4.

[68] The current psychiatric technician to patient ratio at VSH is 1: 4 patients. With the increased professional nurse staffing, we feel the proportion of psychiatric technicians can be reduced. Currently VSH uses 10 average daily constant observations (this is done by psychiatric technicians): because the proposed staffing models offer more nurses, we do not include calculation for constant observations. The Designated hospitals psychiatric inpatient programs do not have comparable psychiatric technician staff positions.

The Futures Advisory Committee consistently commented on the importance of increasing *Peer Support Services*. A number of different types of programs have been discussed including peer-operated group residential services, crisis services, drop-in centers, and peer-to-client outreach programs. In order to develop a cost estimate for some type of peer service, DMH developed cost estimates for a Peer Outreach program targeted at individuals who are in VSH or in the community on outpatient commitment orders. The program would focus on adapting the Recovery Education curriculum for one-to-one work with the clients who are currently at the highest risk for involuntary hospitalization. The cost for this is estimated at $100,000 and the detail can be found in Appendix 14.

Providing safe, clinically appropriate and humane *transportation* to involuntary treatment and to hospital diversion programs has been identified as a critical system component which is currently under resourced. In addition to the funds used to support the current contract with the Sheriff's Association for transportation to involuntary treatment, the Futures plan proposes investing an addition $208,000 annually into training for Sheriffs and to subsidize the development of a voluntary system of transportation. Additional details can be found in Appendix 18.

The cost of the new capacity for ten (10) *crisis triage, diversion, and step down beds* described in this plan is estimated based on the assumption that these beds are added to existing staffed resources (not stand alone programs) such as residential group treatment homes, ADAP programs, crisis diversion / stabilization beds, hospitals and so forth. The estimated cost per bed is derived from the range of current costs to operate substance abuse 24-hr observation beds and mental health crisis stabilization beds. Additional details can be found in Appendix 14.

The fundamental decentralization of the current 54 beds at VSH to a variety of community programs combined with the need to more efficiently use the existing inpatient and crisis beds requires a *care management system*. The cost to link all of the participating providers into a single network in which the needs of patients can be matched to appropriate levels of care is estimated at $275,000. See Appendix 14 for a description of the cost components.

Finally, the VSH Futures Advisory Committee clearly identifies the need for more, *supportive housing* for Vermonters at risk of hospitalization. Therefore, an investment of $500,000 annually is proposed. These funds could be used for rental subsidies or to develop a blended staff (peer and professional) group residential service something like the Safe Haven in Randolph Vermont. The annual costs to staff and operate a group residence for six to eight (6-8) people are about $500,000. Alternatively, at an estimated rent subsidy of $350/month, these funds could be used to provide rental assistance to one hundred and nineteen (119) clients annually.

Finance Strategy

The financing for the Futures plan capacities will build on the existing Intergovernmental agreement (IGA) between the Vermont State Medicaid Authority (OVHA) and the Mental Health Authority to operate the Community Rehabilitation and Treatment (CRT) program under the auspices of Vermont's 1115 Medicaid Waiver. Currently this arrangement provides for an administrative mechanism to match state general funds to federal receipts on a "per member per

month" (capitation arrangement). This capitation arrangement is designed to cover both community and inpatient services for individuals who are clinically eligible for the CRT program (serious mental illness). By arrangement with CMS, there is a defined 'benefit package" or list of covered services. These include services that are traditionally billed to Medicaid[69] and alternative services such as residential and vocational supports. The beneficiaries include individuals who are clinically eligible for CRT and who are enrolled in the traditional Medicaid program and in the VHAP Medicaid expansions program. In addition, the IGA allows the mental Health Authority to cover the cost of services to individuals who are clinically eligible for CRT but not enrolled in Medicaid (at any given time about 15% of the enrollees).

There are two components to the capitation payment, one for the cost of psychiatric inpatient services to CRT enrollees and the other for the cost of community mental health services for program beneficiaries. Most[70] of the program capacities proposed in the Futures plan are all within the scope of covered services in the IGA and Waiver agreement. The most significant restriction on the Federal share of these funds are that they cannot be used to pay for IMD (institute of mental disease) services which specifically are stand alone psychiatric hospitals of more than 16 beds or hospitals in which 50% of the average daily census is psychiatric patients. Therefore, the terms and conditions of the IGA and 1115 Waiver allow federal share participation in the inpatient, sub-acute rehabilitation, secure residential treatment, crisis diversion and triage and care management programs proposed here.

The revenue estimates presume a fifty-fifty match rate (less federal share than the official rate) on the grounds that not all of the clients serviced will be enrolled in the Medicaid program at their point of entry into the system and, in addition, a certain proportion of the clients served in the inpatient and crisis triage capacities may not be clinically eligible for CRT services once the crisis situation has stabilized. In addition, as psychiatric inpatient services at general hospitals traditionally cost more than those provided by IMDs, the OVHA has the authority to raise the rates on the inpatient portion of the capitation agreement if the Divisions of Mental Health can demonstrate increased costs to cover the inpatient component for CRT beneficiaries to provide alternative to IMD services.

[69] These services included psychiatric inpatient care, case management , individual and group therapy, community-based outreach and rehabilitation services, emergency and crisis services.

[70] Medicaid will not participate in the costs of housing, so the $500,000 proposed for housing is not matched. However, Vermont could apply to the Department of Housing and Urban Affairs (HUD) for housing resources, and if funded this would reduce the general fund cost. Alternatively, if the decision is to create a single residential treatment program, the treatment costs for this are allowable under the terms of the 1115 waiver. The Medicaid program is not likely to participate in the costs for a voluntary system of transportation.

Summary

The annual operating costs for the three scenarios outlined in this plan and the general fund resource required are as follows.

Scenario A	
32 Bed Specialized Inpatient w/12 ICU	$ 12,061,187
16 Bed Sub-Acute Rehabilitation	3,714,852
6 Bed Secure Residential Treatment	1,176,557
10 Crisis Diversion Beds	1,000,000
Peer Operated Services	100,000
Housing	500,000
Care Management	275,000
Total Operating	$ 18,727586
General Fund	$ 9,624,793
Federal Funds	$ 9,102,793

Scenario B	
32 Bed Specialized Inpatient w/8 ICU	$ 11,393,745
4 Bed ICU	1,715,725
16 Bed Sub-Acute Rehabilitation	3,714,842
6 Bed Secure Residential Treatment	1,176,557
10 Crisis Diversion Beds	1,000,000
Peer Operated Services	100,000
Housing	500,000
Care Management	275,000
Total Operating	$ 19,875,869
General Fund	$ 10,248,935
Federal Funds	$ 9,626,935

Scenario C	
Two 16 Specialized Inpatient w/4 ICU	$ 12,446,468
4 Bed ICU	1,715,725
16 Bed Sub-Acute Rehabilitation	3,714,842
6 Bed Secure Residential Treatment	1,176,557
10 Crisis Diversion	1,000,000
Peer Operated Services	100,000
Housing	500,000
Care Management	275,000
Transportation	208,000
Legal Services	300,000
Total Operating	$ 21,437,472
General Fund	$ 11,146,176
Federal Funds	$ 10,291,296

See Appendix 15 for Cost Allocation breakdown and Appendix 16 for 5 year trend.

Implementation Phasing

Pending legislative approval, DMH could begin implementation in a phased manner. The timeframe proposed here is aggressive and may be difficult to meet, especially if complications arise with the CON process of inpatient construction (or renovation) or if legislative approval for the plan is not secured. However, the proposed phases here reflect a reasonable sequencing of program implementation.

Phase I

The first phase of the project will be to develop the sub-acute rehabilitation program and secure residential treatment program. This will allow us to close the Brooks Rehabilitation unit and reduce the census at VSH by an average of 12 beds. In addition, throughout Phase I the care management program, transportation system, peer operated service can all be designed and in some cases, implemented. Finally, an application to HUD for additional housing resources would have been made and a funding award announced.

Phase II

During the second phase, the crisis triage, diversion, and step down capacities will be developed. The inpatient partners for the SIP and ICU programs will be identified based on the results of an RFP. Construction of the housing program will have begun. Finally, the full application to BISHCA for the inpatient programs will be completed.

Phase III

In the third phase of implementation, BISHCA will make its final determination of the CON for the inpatient programs. All the residential and diversion resources should be up and running. Planning for the proposed construction of inpatient programs should be complete.

Phase IV

In the final phase, construction of the inpatient programs will be completed and the programs will open.

A detailed timeline with project milestones is in Appendix 17.

Part VI: The Planning Process, Advisory Committee and Public Input

The Planning Process

A core work group comprising leadership the Divisions of Mental Health met weekly since early March to develop this plan. The core team commissioned clinical, fiscal, and quantitative analyses to inform the development of preliminary concepts. Input from the public and interested parties was elicited and received through: the Vermont State Hospital Futures Advisory Group, the Mental Health Oversight Committee, and statewide hearings through Vermont Interactive Television Network (VITN), and meetings with key stakeholder groups. At each juncture, the developing concepts were refined resulting in a dynamic planning process. (See Appendix 18)

The Request for Information

The planning process culminated in a formal Request for Information (RFI) issued in mid December in which the Division described the service capacities envisioned to replace the functions of VSH and transform the system of care. The response to the RFI was overwhelmingly positive. Four of the five hospitals with psychiatric inpatient services responded as did almost all of the Designated Agencies. Multiple potential partners expressed strong interest in collaborating with the Division to implement the programs and supports proposed (see Appendix 19 and 20 for the RFI and Responses). In addition, while the responders noted the large scope of system transformation entailed in the draft plan, the responses were creative and innovative.

The VSH Futures Advisory Committee

As detailed in the legislation, the Division empanelled an advisory committee to provide feedback into the development of this plan. The Vermont State Hospital Future Planning Advisory Group was formed by amending the membership of an existing group charged with advising the Division of Mental Health on the recertification process for VSH. The newly formed group began its work on the Futures project in March 2004 and has met at least twice a month since then. In addition, the group has held two full day planning retreats. All of these meetings were attended by members of the public who were provided dedicated time on the agenda to comment. The minutes of these meetings and materials were circulated to a distribution list of over eighty interested individuals and organizations. The Division of Mental Health has staffed these meetings to provide guidance and materials. Since September, the Division contracted with Gretchen Cherington, of GC Consulting to provide meeting facilitation. See Appendix 21 for a list of current members of the Vermont State Hospital Future Planning Advisory Group.

APPENDICES

Appendix 1

Department of Health Initiatives

The Department of Health is involved in an ad-hoc group called "Vermonters for Suicide Prevention" which includes Senator Condos and Representatives Donahue and Rusten. Since 90% of all people who commit suicide have a diagnosable mental illness, the Department of Health is developing a comprehensive prevention plan for early detection and intervention of mental illness. Research has demonstrated that effective suicide prevention goes beyond single targeted programs and includes an array of prevention activities at multiple levels targeting many mental health programs.

The Department of Health, in conjunction with the Department of Children and Families, is working on the "Challenges and Solutions to Implement Integrated Services for Co-Occurring Mental Health and Substance Abuse Issues with Children, Youth and Families." The goals of this task force are:

1. Funding streams will support integrated treatment approaches
2. Organizational structures and cultures will embrace:
    a. Collaborative, integrated treatment approaches
    b. Family and youth centered practices
3. State government and private non-profits will devote training and professional development resources to support the staff to integrated treatment

State government and non-profits will follow the same standards for integrated treatment in all mental health and substance abuse treatment settings.

Appendix 2

VSH Bed Need Calculations: FY'02, '03 and '04

	Fiscal Year		
	2002	2003	2004
Average VSH In-House Census	49	46	46
Bed Need Estimate #1	61	58	57
Bed Need Estimate #2	54	53	50
Bed Need Estimate #3	57	57	52
Bed Need Estimate #4	54	53	50
Bed Need Estimate #5	56	56	51

#1 – Based on Paul WB's formula (using assumed standard deviation)
#2 – Based on calculation using actual standard deviation
#3 – Based on maximum daily census
#4 – Based on actual daily census: would yield bed shortage one day per month
#5 – Based on actual daily census: would yield bed shortage one day per quarter

Appendix 3

People, Admissions, and Length of Stay For Patients Admitted to the Vermont State Hospital for Forensic Observation: FY 2003 by Type of Offense and Gender

Offense	Number of People			Number of Admissions			Average Length of Stay	
	Total	Male	Female	Total	Male	Female	Male	Female
Total	**99**	**78**	**21**	**103**	**82**	**21**	**59**	**58**
Total Felony	**27**	**24**	**3**	**27**	**24**	**3**	**94**	**116**
Violent Felony	16	13	3	16	13	3	98	116
Non-Violent Felony	12	12	0	12	12	0	83	0
Total Misdemeanor	**80**	**60**	**20**	**84**	**64**	**20**	**41**	**60**
Violent Misdemeanor	32	25	7	32	25	7	33	96
Non- Violent Misdemeanor	54	39	15	58	43	15	44	40
Total Violent	**45**	**36**	**9**	**45**	**36**	**9**	**58**	**80**
Violent Felony	16	13	3	16	13	3	98	116
Violent Misdemeanor	32	25	7	32	25	7	33	96
Total Non-Violent	**64**	**49**	**15**	**68**	**53**	**15**	**54**	**40**
Non-Violent Felony	12	12	0	12	12	0	83	0
Non-Violent Misdemeanor	54	39	15	58	43	15	44	40

Average Length of Stay calculations exclude one individual who had not been discharged as of the date of this analysis.

Totals for each type of charge may not reflect the sums of the numbers of the sub-types because a person/admission may have more than one type of charge.

A felony is a crime punishable by more than two years imprisonment. Examples include murder, aggravated assault on a police officer, sexual assault on a minor, and kidnapping.

A misdemeanor is a crime punishable by two years imprisonment or less. Examples include disorderly conduct, simple assault, bad check, and negligent operation.

Revised December 15, 2004

Appendix 4

People, Admissions, and Length of Stay For Patients Admitted to the Vermont State Hospital for Forensic Observation: FY 2003 by Type of Offense

Offense	Number of People	Number of Admissions	Average Length of Stay	Percent Discharged Within…			Average Daily Census
				1 Month	1-3 Months	> 3 Months	
Total	**99**	**103**	**59**	**60%**	**20%**	**20%**	**17**
Total Felony	**27**	**27**	**97**	**59%**	**11%**	**30%**	**7**
Violent Felony	16	16	102	63%	12%	25%	4
Non-Violent Felony	12	12	83	58%	9%	33%	3
Total Misdemeanor	**80**	**84**	**46**	**62%**	**21%**	**17%**	**11**
Violent Misdemeanor	32	32	47	66%	18%	16%	4
Non- Violent Misdemeanor	54	58	43	62%	22%	16%	7
Total Violent	**45**	**45**	**62**	**64%**	**18%**	**18%**	**8**
Violent Felony	16	16	102	63%	12%	25%	4
Violent Misdemeanor	32	32	47	66%	18%	16%	4
Total Non-Violent	**64**	**68**	**51**	**60%**	**21%**	**19%**	**10**
Non-Violent Felony	12	12	83	58%	9%	33%	3
Non-Violent Misdemeanor	54	58	43	62%	22%	16%	7

Average Length of Stay calculations exclude one individual who had not been discharged as of the date of this analysis.

Totals for each type of offense may not reflect the sums of the numbers of the sub-types because a person/admission may have more than one type of charge.

A felony is a crime punishable by more than two years imprisonment. Examples include murder, aggravated assault on a police officer, sexual assault on a minor, and kidnapping.

A misdemeanor is a crime punishable by two years imprisonment or less. Examples include disorderly conduct, simple assault, bad check, and negligent operation.

Revised December 15, 2004

Appendix 5

The Designated Agency System

A study of the sustainability of the DA system was completed in November of 2004 by the Pacific Health Policy Group. Among the report's chief findings are these contained in its executive summary: *"The Designated Agencies have, by and large, been successful in operating efficient, community-based systems for a wide range of behavioral and developmental services. The non-competitive nature of the DA system and the bottom-line regional responsibilities delegated to the Designated Agencies has fostered the development of a system of care that is highly effective in meeting the unique needs of Vermont communities.*

The DA system, administered by DMH, focuses on five programs:

- Community Rehabilitation and Treatment (CRT) – comprehensive services for adults with long term psychiatric disabilities. In SFY 04, 3,205 individuals were served.
- Adult Outpatient Services – individual and group counseling for adults with serious mental health issues. In SFY 04, 7,120 individuals were served.
- Emergency Services – evaluation and support services provided to individuals and communities experiencing a crisis. In SFY 04, 6,690 individuals were served.
- Inpatient Treatment – namely, the services at VSH and oversight responsibility for involuntary inpatient care statewide. In SFY 04, 549 individuals were served. (DMH directly operates the services at VSH and provides oversight for involuntary admissions to DAs and Retreat Healthcare and for all Medicaid-funded admissions of CRT clients and children for psychiatric inpatient care.)
- Services for Families and Children – immediate response, treatment, family support services and consultation, intensive residential, prevention and education. In SFY 04, these programs served 10,040 children.

Regarding Community Rehabilitation and Treatment:

Vermont's CRT programs assist adults who have been diagnosed with a mental illness and who are experiencing disability. The programs serve 3,200 individuals in any given year and help individuals and their families to develop skills and supports. Some of the services are medication prescription and monitoring; community supports; helping individuals find and keep a job or a place to live, get an education, understand their mental illness, meet life goals; crisis services; social and recovery skills. The CRT program operates under the auspices of a Federal Section 1115 Research and Demonstration Waiver and provides comprehensive outpatient treatment and services to seriously mentally ill adults in the state as an alternative to inpatient treatment. It is the only such federal demonstration program in the country.

Although the CRT program is relatively well developed, it faces significant challenges in staff turnover, shortage of housing for clients, implementation of evidenced-based practices, and the need to become a system informed about and capable of addressing the impact of trauma on the lives of clients.

Regarding Adult Outpatient Programs:

Adult Mental Health Outpatient Programs, sometimes referred to as family programs because so may of these adults have children being served by other agency of human services programs, serve more than 7,000 Vermonters a year. The individuals seeking mental health outpatient services typically experience severe dysfunction in family, social, occupational, and self-care roles. Most (53 percent) have marital and family problems and many have histories of psychological trauma that impair current functioning, problems with daily living, social and interpersonal problems, medical and somatic issues, are suicidal and/or abuse drugs and/or alcohol. Adult outpatient programs are not statutorily mandated and have experienced significant erosion of funding and service capacity even in the face of increased demand for these services.

Regarding Emergency Services:

Vermonters should be able to receive rapid response and assistance from skilled mental health professionals in times of personal and community crisis. An estimated 7,000 people received emergency services from the public mental-health system in SFY 2004. These services, available 24 four hours a day, seven days a week, serve not only individuals but also communities and organizations that are trying to cope with traumatic or tragic events, such as a natural disaster, homicides or suicides. They include

- 24-hour-a-day telephone support.
- Face-to-face evaluation and referral (mobile crisis team).
- Screening for court-ordered observations in criminal cases.
- Acute care and involuntary assessments (facility based).
- Community liaison with law enforcement, schools, courts, etc.
- Response to community trauma and disasters.

Two important resources for individuals in crisis are crisis stabilization programs and diversion services, which are held to be very effective in reducing hospitalization. The names and locations of Vermont's four crisis stabilization/inpatient diversion programs are shown in Appendix 11. They are not distributed evenly around the state, which creates significant issues of access. These programs also are often underutilized.

Appendix 6

CRT Program Housing Inventory [1]
Subsidized and/or Supportive Housing
October 2004

Designated Agency	Adult [2] Population	CRT Clients Served FY '04	VSH In-House Census Oct. 15	DMH Rent Subsidy [3]	Group Home Beds	Hospital Diversion Step Down Beds	Other HUD [4] Subsidized DA Supported Beds
CMC	29286	169	1	$22,882	6	0	6
CSAC	27582	173	3	$10,331	6	0	18
HCRS	74818	429	4	$29,582	18	4	35
HCHS	114975	671	17	$74,167	41	12	19
LCMH	18884	138	3	$32,490	27	0	0
NKHS	49441	411	5	$16,670	3	5	5
NCSS	41076	250	5	$15,711	12	0	10
RMHS	50094	310	4	$35,882	0	1	19
UCS	29228	192	1	$34,417	6	6	6
WCMH	46231	462	3	$29,664	16	5	5
TOTAL	**481615**	**3205**	**46**	**$301,796**	**135**	**33**	**123**

[1] = Includes housing operated or staffed by Designated Agency provider network.
[2] = Calendar year 2003; adult population of Designated Agency catchment area.
[3] = Housing Contingency Fund.
[4] = Shelter Plus Care.

Appendix 7

HOUSING NEEDS – A BRIEF SURVEY
VSH FUTURES PROJECT

QUESTION 1: How long does it currently take to get a CRT client housing in your community (e.g. physically into an apartment)? Can you briefly describe the kinds of availability and access issues that you commonly encounter?

CMC	Depends on client ability to pay for housing and the town they are needing housing in. Due to large geographic area in part, it exceeds **1 month**. In Bradford, the majority of housing is sub-standard and is more available than in Randolph. For individuals on SSI only, the subsidized and un-subsidized housing market is out of reach. The cost even with subsidy is now sometimes $25 more than the Section 8 program will allow.
CSAC	Takes **2-3 months** to get someone into an affordable apartment (Section 8 or S&C) only if they have a deposit, good credit history, good landlord references, and no criminal convictions, and that drug/alcohol issues are under control. If they have no income and there is no Section 8 or S&C available, they are not "houseable". HCF cannot financially support the individual with no income. A one-bedroom rent is currently $650/month in Middlebury.
HCRS	It varies from community to community in HCRS. White River Junction is the most difficult; Brattleboro is second, followed by Springfield (Springfield is most impacted by Corrections needs). Ludlow has tourist interests competing. It took **6 months** to find independent housing for the most recent client transitioning out of Beekman house (residential group treatment program).
HCHS	From start to finish, I think it takes usually at least **two months**, sometimes longer. Finding an apartment in this town is challenging, especially if a client has poor or no references. Our supply of designated units from Lake Champlain Housing and Burlington Community Land Trust has been invaluable; without this "in", it's an uphill battle. The lack of Section 8 is now a serious access issue along with the inadequate amount of Housing Contingency Fund money (DMH Housing subsidy).
LCMH	Currently it takes **1 month or longer**. There is 1 person in transitional housing looking and it is taking more than 3 months. There are also a few that have taken 1-3 months. The problem is that this is taking up a bed that could be used for a step-down from the hospital. There are now 2-3 referrals from VSH and Springfield Correctional Center who need housing in order for them to be discharged to the community, and we have no housing that will be safe and secure for the community. In the past, the community has been up in arms to hear of the possibility of housing these clients. Best case scenario to get into a group home is 3 months. This is the first time in our history there may be homeless people in the community. People with corrections backgrounds create a more difficult challenge.

NKHS	There is a shortage of apartments in the area. Our transitional program is generally full with no opportunity for current residents to move into independent living. There are few landlords in town and if the client is known for bad behaviors and poor tenant history they are harder to get a unit for. Even with a unit it takes 2+ weeks when a unit becomes available to assemble the resources. Security deposit and first and last month's rent requirements add up to $1,500. If the agency can, it works with the landlord to waive last month's rent. The cost of housing in the Kingdom used to be relatively inexpensive and now it is catching up to outside the area. Some 1-BR are $500 and 2 BR are more.
NCSS	The issue is if they have Section 8 or not (eg if they have a subsidy). If they have only SSI income, they would likely be homeless before they could get a unit. It could be 2 years if the client went through transitional housing (HUD-funded program at NCSS). If they had resources it could be as little as **one month to 24 months**. There are units in town and out of town but it all depends on the level of income and transportation. Income is key.
RMHS	There is an influx of people who do not meet strict CRT eligibility and they are carrying a correctional component to their history. These folks might have gone into adult patient, but that is no longer available. They take a longer time to house, usually a minimum of a month. There is one HCF recipient who has waited for 5 years to get a permanent HUD subsidy. The average wait for a housing subsidy is approximately 3.5 years.
UCS	Landlords all know each other and when someone has a poor history they are very difficult to house. The increased cost of security deposits, and first and last month's rent, is now about $1500 per person. Transportation is a hardship factor here and the less expensive units in outer areas are not available to clients because of lack of access.
WCMH	A newly emerging issue is finding housing for people who are heavy smokers. Finding apartments that fit within Section 8 guidelines (cost and habitability) is difficult we have someone has been in a motel for 6 months for instance. Finding an apartment in Montpelier is next to impossible. There is a definite need for more housing in Montpelier. Affordable housing is a large issue in Montpelier for all. The income of clients is a key piece of this.

QUESTION 2: How many, in any, CRT clients *this week,* are "waiting" for housing (e.g. typical housing such as apartments)?

CMC	There are 4 individuals who are actively looking and meet HUD definition of homeless. In addition, there are 5 more who are looking for housing also – this makes a **total of 9**.
CSAC	Currently, there are **9 CRT clients** this week that are waiting for housing (a typical housing situation).
HCRS	**13 CRT clients**
HCHS	**4 CRT clients**
LCMH	Between transitional and other referrals including those using Section 8 HCF and the 2 waiting for HCF (2), the total is **11 individuals**. The amount of

	monies for start-ups is more than ever before. Security deposits and start-ups is growing very quickly. Utilities, propane deposit, request first and last deposits for the apartment unit, etc.
NKHS	Here we have **10** between Newport and St J. There is one individual in the community that is virtually unable to be housed in either community. A correction history is an impediment here. The local housing management (NCMC) does a background check on applicants.
NCSS	**10**
RMHS	There are **5 clients** waiting for housing. There are 4 without subsidy and no permanent housing: 2 in transitional; 1 in Emergency; and 1 DV case where the wife threw the client out.
UCS	Only have **1 homeless** client now.
WCMH	In group homes waiting to get into apartments, there are 5 people waiting on HCF and 2 waiting to get on HCF for a **total of 9**.

QUESTION 3: How many, if any, CRT clients *this week,* are waiting for some type of staffed or supported housing (home care provider, residential group home, and community care home)?

CMC	There are **2** people in this category.
CSAC	There are **4** clients waiting THIS WEEK for some type of staffed or supported housing.
HCRS	The need is Brattleboro for 6 conservatively, and there is a wait list at Beekman house, so 4 more in this area and north. **At least 10 conservatively**.
HCHS	**17**
LCMH	If there were openings we could have had **4 placements** over the last quarter, 3 of those would have been corrections. And the safety issues would have to be considered. Liability questions on insurance costs are being raised for those with convictions.
NKHS	Between Newport and St J, that would be a **total of 8** (4 in each area).
NCSS	**5**
RMHS	One waiting for community care that is very difficult to place. One needing supportive, and 3 others, for a **total of 5**.
UCS	No staffed housing needed right now. South Street is at full now. People with physical difficulties are challenging for those looking for residential settings. Smoking issues present as a problem also.
WCMH	There are some clients who could be served in supportive housing. There is a client in Home Intervention who has been there for 4 months and are needing supportive housing options. They had a home care provider previously, and there are no options. Currently there are a few individuals who are in apartments that would like a more supportive environment – that number is 5. This makes a **total of 6**.

QUESTION 4: Overall, what are the most serious housing issues clients in your community face?

1. Lack of available rental housing
2. Housing is too expensive for consumers' incomes
3. Lack of supportive housing (home care providers, residential group homes, community care homes)?

CMC	"They are all very important. There is only one community care home in the county. Safe Haven is full. Transitioning people from SH is difficult. Housing is too expensive #1; Lack of available rental housing #2; Lack of supportive housing #3. Bradford area could use supportive housing and Randolph area could use more rental units that are affordable.
CSAC	Lack of supportive housing in the area ranks as #1; the community care homes in Addison County are too costly and are therefore not available – housing is too expensive #2; and lack of available housing #3.
HCRS	Lack of affordable housing rental units.
HCHS	Our most serious housing issues are lack of community care home beds, a lack of Section 8 vouchers (housing is too expensive for our client's incomes), and the extremely low vacancy rate in Burlington. Also - nursing home beds!
LCMH	Number of available units is #1, but you have to speak in terms of affordability. The agency lost availability when a landlord raised rents beyond what is affordable. Number one is really a combo of numbers 1 and 2; supportive housing is 3rd. Note: there may be a need to create a new category for supervised housing for corrections folks given a number of risk factor(s) and one for those non-corrections with bracelets and alarmed doors in the community with the higher level of supervision required.
NKHS	Lack of units, but in particular, lack of units that are affordable. Supportive housing would be 3rd. For the area situation they feel they have done well. If they had 6 transitional housing units they would be in a better situation.
NCSS	All 3 are connected. In degree of severity, affordability is the primary issue. If units were more affordable, people would have more access in the community. Supportive housing, like 174 or 22 (residential group home and HUD transitional housing), really could be increased. Also, more home care providers or other types of assisted living approaches would really help out.
RMHS	Lack of supportive housing is most serious. We need something more special than what we have. Clients are prone to violence in some instances, and have corrections backgrounds as well, usually dually diagnosed. There is a need for staff capacity in this area, as well as the actual housing options.
UCS	The lack of affordable rental housing units is the overwhelming issue – the affordability factor is most important here. It is more expensive than our folks can afford. It is not that there is a shortage of units; it is that they are not affordable. Residential or group housing would be last in this ranking here.
WCMH	Lack of transportation exacerbates these problems. Ranked in order: Lack of availability #1; Housing is too expensive #2; Lack of supportive housing #3.

Appendix 8

Unduplicated Number of Adults Hospitalized
for Behavioral Health Services
Vermont **Adults**: 1992-2002

Unduplicated Number of People Served by Hospital Type

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Total	2,385	2,456	2,590	2,539	2,682	2,669	2,635	2,627	2,864	2,920	3,116
VT General Hospitals	1,567	1,554	1,617	1,538	1,755	1,748	1,704	1,799	1,967	1,910	2,070
Vermont State Hospital	348	322	342	330	286	311	265	261	226	263	229
Brattleboro Retreat	175	198	225	319	350	405	363	366	463	531	549
VA Hospital - WRJ	164	187	192	200	182	146	141	147	169	157	161
New Hampshire Hospitals	341	416	467	456	396	305	324	295	299	325	330
Out-of-State Hospitals	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Unduplicated Number of People Served by County of Residence

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Total	2,385	2,456	2,590	2,539	2,682	2,669	2,635	2,627	2,864	2,920	3,116
Addison	86	110	100	105	107	121	109	123	116	129	130
Bennington	41	44	49	67	56	146	135	131	149	153	197
Caledonia	117	128	121	128	111	104	97	89	100	106	107
Chittenden	530	518	563	502	524	557	527	504	573	565	581
Essex	25	30	24	26	33	28	30	29	21	29	22
Franklin/Grand Isle	139	130	143	113	145	139	121	118	146	166	186
Lamoille	75	74	66	65	67	62	76	79	107	101	94
Orange	110	111	111	121	120	112	109	109	113	125	152
Orleans	103	123	114	105	107	114	99	127	101	104	102
Rutland	287	258	285	296	284	298	386	393	487	463	490
Washington	324	283	298	290	321	361	312	303	312	331	349
Windham	204	222	262	280	340	368	377	332	336	344	375
Windsor	292	345	350	360	364	313	323	328	358	366	364
Unknown	3	12	16	18	16	13	24	67	18	33	27

Information is derived from the Hospital Discharge Data Set maintained by the Vermont Health Department, and database extracts provided by the Brattleboro Retreat and Vermont State Hospital.

The State of Vermont does not have unique client identifiers across service providers. For this reason, Probabilistic Population Estimation has been used to provide unduplicated counts of people served (with 95% confidence intervals). Estimates of the number of people served by Massachusetts and New York hospitals are not provided because the data is inadequate to provide probabilistic population estimates. Actual person counts are available for Brattleboro Retreat and the Vermont State Hospital.

Vermont adults include residents age 18 and older.

Appendix 9

Episodes of Hospitalization Per 100,000 Population
for Behavioral Health Services
Vermont **Adults**: 1992 - 2002

Episodes per 100,000 Population by Hospital Type

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Total	786	830	872	874	941	930	898	893	937	938	960
VT General Hospitals	462	466	500	473	553	566	537	562	585	570	592
Vermont State Hospital	93	88	91	86	78	84	67	63	56	64	56
Brattleboro Retreat	48	57	62	87	106	114	125	101	125	149	142
VA Hospital – White River Jct	43	35	37	35	31	52	52	56	56	50	55
New Hampshire Hospitals	117	150	158	161	149	91	92	89	96	95	89
Other Out-of-State Hospitals	23	34	23	31	24	23	24	23	20	9	26

Episodes per 100,000 Population by County of Residence

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Total	786	830	872	874	941	930	898	893	937	938	960
Addison	487	570	582	563	697	691	596	889	762	780	666
Bennington	798	993	1,007	1,139	1,100	759	722	748	818	776	1,072
Caledonia	711	805	715	776	777	696	619	573	613	688	656
Chittenden	670	691	756	671	662	734	703	629	734	689	701
Essex	615	736	648	728	892	751	835	752	562	702	497
Franklin/Grand Isle	545	492	511	402	565	493	433	397	515	583	626
Lamoille	617	615	577	553	638	691	646	751	819	819	694
Orange	866	1,009	759	858	858	772	704	717	824	848	1,073
Orleans	775	909	976	794	778	831	708	890	727	715	640
Rutland	805	741	813	875	852	901	1,151	1,172	1,389	1,396	1,456
Washington	1,142	1,036	1,161	1,095	1,326	1,396	1,046	1,044	1,140	1,169	1,153
Windham	916	1,090	1,142	1,440	1,732	1,871	1,909	1,620	1,435	1,529	1,572
Windsor	1,042	1,149	1,305	1,312	1,379	1,188	1,235	1,225	1,275	1,161	1,153
Unknown	1	3	4	5	4	5	6	15	4	8	6

Information is derived from the Hospital Discharge Data Set maintained by the Vermont Health Department, and database extracts provided by the Brattleboro Retreat and Vermont State Hospital.

Vermont adults include residents age 18 and older.

Population figures used to calculate rates were obtained from the 1990 through 2001 Vital Statistics Reports published by the Vermont Department of Health.

Appendix 10

Possible Management/Alignment Inpatient Scenarios For Replacement of VSH

State/Private-Run Options **(must be 16 beds or less at each site to maximize federal revenue)**		
Management/Staff	**Building Site** **(Proximate to existing hospital preferred)**	**Who Constructs**
State/State	Anywhere	State **OR** Private Developer
Private/Private or State	Anywhere	Provider, State or Private Developer

Private General Hospital-Run Options **(see chart below for # of beds possible for each specific hospital to maximize federal revenue by avoiding IMD designation)**		
Management/Staff	**Building Site**	**Who Constructs**
Private General Hospital/Private General Hospital	Private Hospital grounds OR w/in 35 mile radius of main campus	Hospital, State or Private Developer
Private General Hospital/State (under contract w/hospital)	Private Hospital grounds OR w/in 35 mile radius of main campus	Hospital, State or Private Developer

Private General Hospital (by CMS regulation, hospitals with more than 50% of their acute Avg Daily Census as psychiatric admissions are considered IMDs)	**Estimated Additional Behavioral Health Capacity at 50% ADC Limit**
Brattleboro Memorial	12
Central Vermont	14
Copley	5
FAHC	126
North Country	7
Northwestern	12
Porter	6
Rutland Regional	23
Southwestern	24
Springfield	4

Critical Access Hospitals (by federal definition, these hospitals can only have a maximum of 25 beds, but are allowed up to 10 psychiatric beds that do not count toward their 25 maximum)	**Possible Additional Behavioral Health Capacity**
Gifford	10
Grace Cottage	10
Mount Ascutney	10
Northeastern	10

Appendix 11

Crisis Stabilization Programs

Existing crisis stabilization/hospital diversion beds are available only in four DA catchment areas[1] and often only to known clients. These programs also operate under capacity indicating that the existing crisis beds could be made more available to other geographic areas.

Crisis Stabilization Facility	Location	No. Crisis Beds
Alternatives (HCRS)	Springfield (Windsor County)	4
Assist (HCHS)	Burlington (Chittenden County)	4
Battelle House (UCS)	Bennington (Bennington County)	5
Home Intervention (WCMHS)	Barre (Washington County)	6

Vermonters in crisis sometimes wait undue lengths of time in hospital emergency rooms while the process of finding an alternative to hospitalization, including hospital placement bed unfolds for hours. In many instances, the crisis itself escalates and the individual may no longer be able to voluntarily accept treatment. The delay in getting an individual in crisis into a safe, treatment environment also limits the range of stabilization and supportive interventions that the system can bring to the situation. A safe pre-admission/triage bed may increase client choice and the use of natural support networks, and may allow time for the development of more appropriate disposition plans.

[1] A catchment area is the defined geographical region served by a single Designated Agency. In the current system, crisis stabilization beds are available in Chittenden, Washington, Bennington, Windsor and Windham counties.

Appendix 12

Staffing Assumptions

Staffing Model for Specialized In Patient Care (SIP)

Direct Care Staff
1:4 nurse to patient ratio[1]
1:8 psychiatric technicians[2] to patient ratio
1:8 psychiatrist to patient ratio
1.5 FTE psychologist for 32 bed configuration; 1 FTE for 16 bed configuraration
1:8 social worker to patient ratio
1:8 Activity/ Occupational staff to patient ratio

Support Staff
1:4 cooks/housekeepers to patient ratio
3 FTE business office staff for 32 bed configuration; 2 FTE for 16 bed program
4 FTE secretarial staff (ward clerks, health information officer, transcriptionist) for 32 bed program; 3 FTE for 16 bed configuration
1 FTE pharmacist for 32 bed; 50FTE for 16 bed program
1 FTE quality management /risk management specialist for each program configuration
1: FTE patient relations (admissions staff, benefit specialist, receptionist) for each program configuration
5 FTE senior leadership for 32 bed configuration; 2.5 FTE for 16 bed program
1 FTE nurse/unit manager for each configuration
1 FTE nurse educator for each configuration

Operating Costs
$19,000/bed (supplies, furniture, food, services, pharmacy, equipment leasing costs etc.)

Staffing Model for the Intensive Care Units (ICU)

Direct Care Staff
1:2 nurse to patient ratio
1:4 psychiatric technicians to patient ratio

All other staffing and operational costs are the same as for the SIP

[1] The current nurse to patient ratio at VSH is 1:10 patients. By comparison, the Fletcher Allen Health Care union contract requires a nurse to patient ratio of 1:4.
[2] The current psychiatric technician to patient ratio at VSH is 1: 4 patients. With the increased professional nurse staffing, we feel the proportion of psychiatric technicians can be reduced. Currently VSH uses 10 average daily constant observations (this is done by psychiatric technicians): because the proposed staffing models offer more nurses, we do not include calculation for constant observations. The Designated hospitals psychiatric inpatient programs do not have comparable psychiatric technician staff positions.

Staffing Model for the Sub Acute Rehabilitation Program

Direct Care Staff

1: 16 nurse to resident ratio
1:4 psychiatric technicians to resident ratio
1 FTE social worker
5 FTE activity / occupational therapists

All other professional services (psychiatry, psychology, drug and alcohol treatment services etc.) are contracted for.

Support Staff

1:4 cooks/housekeepers to resident ratio
1.5 FTE senior program leadership
1 FTE administrative assistant / clinical records specialist
1 FTE quality and risk management staff
50% FTE accountant

Operating Costs (supplies, furniture, food, services, equipment leasing costs etc.) are $304,00 for the program annually.

Staffing Model for the Secure Residential Facility

Direct Service Staff

1 FTE nurse
1:3 ratio psychiatric technicians to resident ratio (2 staff all shifts)
1 FTE activity / occupational therapist
50% FTE social worker

All other professional services are provided by existing community mental health and health care services.

Support Staff

1 FTE program director

Operating Costs (supplies, furniture, food, services, equipment leasing costs etc.) are $78,444 annually.

Appendix 13

Basis for Costs

Peer Operated Services (Community Links Project) (100,000)

This program matches trained peers with individuals who are at VSH or in the community on an order of non-hospitalization.[1] The peers work one-to-one with patients to help them learn and use skills to better manage mental illness and to create supportive networks in the community. This would be targeted to twenty individuals a year.

Project Coordinator 1 FTE @ entry level state salary PG 24 plus Fringe @30% = $52,000
Contracted Evaluation services 4,000
Training for Peers 4,000
Travel 8,000 miles @ .345/mi 2,760
Wages for 20 peer-patient matches 37,240
Twenty peer-client matches; 12 hours of direct service per month per match; 2 hours of training and supervision per month per match: @ hourly wage plus payroll tax.

Assumes office space, telephone, copier, postage are all in-kind contributions, no fee for indirect.

Transportation (208,880)

The cost basis for transportation services is derived from the following assumptions. Staffing and mileage costs are calculated based on 475 trips/yr at an average of 80 miles per trip. The staff will cost $15.00 an hour and it will take 5.6 FTE staff to cover the state and be available 24 hrs a day, 7 days a week. The mileage costs are based on the current state reimbursement of .36 /mile. Finally, $20,000 is proposed to pay for the training for Sheriffs on use of a new protocol to assess the clinical basis for type of transport and safety risks.

Staff costs 175,200
Mileage 13,680
Sheriff training 20,000

Crisis Triage / Diversion Beds ($1,000,000)

The estimated cost per bed is derived from the range of current costs to operate substance abuse 24-hr observation beds and mental health crisis stabilization beds. ADAP estimates that the annual costs for 24-hr substance abuse observation bed is $63,875 ($175/day)[2]. The cost of the substance abuse observation bed at the Battelle House program operated by United Counseling Services is $86,000[3]. The existing MH crisis stabilization/diversion beds cost between $105,393

[1] Orders of non-hospitalization are a form of outpatient commitment in which an individual committed to the care and custody of the Commissioner of Health (formerly Mental Health) agrees to conditions of community release and if these conditions are violated the State may seek to re-hospitalize the individual.
[2] Personal communication with Peter Lee, ADAP clinical operations.
[3] Personal communication with Maryanne Nesbitt, CFO United Counseling Services

(Batelle House) to $146,354 (Home Intervention) annually. The staffing for the MH crisis beds varies by program but usually includes to staff for every four patient beds for each shift. Of these, one shift per weekday may be staffed by a nurse. There is psychiatric and nursing back-up on call. Assuming that these capacities can be developed in conjunction with already staffed facilities, we estimate that each bed would cost $100,000 annually.

Care Management $275,000

This includes two professional FTE staff (state pay grade level 24) and a 50% FTE manager (state pay grade level 26). In addition, it includes $100,000 to purchase and adapt a care management computer software system. This assumes that the current VDH care management staff would also continue to perform these roles.

VSH Futures Cost Project
Summary Sheet

	32 Bed SIP w/12 Bed ICU	32 Bed SIP w/8 Bed ICU	28 Bed SIP w/8 Bed ICU	16 Bed SIP W/4 Bed ICU	4 Bed ICU	16 BED Rehab	6 BED Residential
Staffing:							
Nursing Service	4,826,571	4,346,191	3,923,012	2,173,096	903,559	1,167,390	460,296
Other Direct Care Staff	972,307	972,307	972,307	548,846	107,324	271,607	99,694
Support Staff	1,368,378	1,368,378	1,368,378	908,570	59,321	350,718	156,671
Total Salary Expenses	**7,167,256**	**6,686,876**	**6,263,697**	**3,630,511**	**1,070,203**	**1,789,715**	**716,661**
Total Benefits 32.87 % of salary: (Includes Payroll Taxes, Health, Dental, Life, Pension)	2,355,877	2,197,976	2,058,877	1,193,349	351,776	588,279	235,567
Total Salary-related expenses	**9,523,133**	**8,884,852**	**8,322,574**	**4,823,861**	**1,421,979**	**2,377,995**	**952,228**
WC	426,953	398,337	373,128	216,270	63,752	106,613	42,692
Unemp	8,134	7,589	7,109	4,120	1,215	2,031	813
On-Call Dr	250,000	250,000	250,000	250,000		125,000	0
Contracts	348,439	348,439	348,439	174,219	39,589	348,439	0
Total Non Salary PS	**1,033,526**	**1,004,365**	**978,676**	**644,609**	**104,555**	**582,083**	**43,505**
Total Personal Services Expenses	**10,556,659**	**9,889,217**	**9,301,250**	**5,468,470**	**1,526,535**	**2,960,078**	**995,733**
Other Operating Expenses	**608,000**	**608,000**	**532,000**	**304,000**	**76,000**	**304,000**	**78,444**
Total Operating Expenses	**11,164,659**	**10,497,217**	**9,833,250**	**5,772,470**	**1,602,535**	**3,264,078**	**1,074,177**
Plant Depreciation	509,821	509,821	446,094	254,911	63,728	254,911	57,475
Equipment Depreciation	15,000	15,000	13,000	10,000	3,000	10,000	3,000
Fee for Space	**371,706**	**371,706**	**325,243**	**185,853**	**46,463**	**185,853**	**41,905**
Total Cost	**12,061,187**	**11,393,745**	**10,617,587**	**6,223,234**	**1,715,725**	**3,714,842**	**1,176,557**
Plant Construction	15,294,644	15,294,644	13,382,814	7,647,322	1,911,831	7,647,322	1,724,250

Appendix 15

Cost Allocation Breakdown

COST ASSUMPTIONS			FUNDING		
Inpatient Configurations			General Fund	Federal	
	32 Bed Specialized Inpatient w/ 12 Bed ICU	$12,061,187	$6,030,594	$6,030,594	*
	32 Bed Specialized Inpatient w/ 8 Bed ICU	$11,393,745	$5,696,873	$5,696,873	*
	16 Bed Specialized Inpatient w/ 4 Bed ICU	$6,223,234	$3,111,617	$3,111,617	*
	4 Bed Intensive Care Unit	$1,715,725	$857,863	$857,863	*
16 Bed Sub Acute Rehabilitation Program		$3,714,842	$1,857,421	$1,857,421	*
6 Bed Secure Residential		$1,176,557	$588,279	$588,279	*
Peer Operated Services		$100,000	$100,000	$0	**
Legal Service		$300,000	$162,000	$138,000	***
Transportation		$208,880	$208,880	$0	**
Crisis Triage / Diversion Beds ($100k/bed)		$1,000,000	$500,000	$500,000	*
Housing		$500,000	$500,000	$0	**
Care Management		$275,000	$148,500	$126,500	***

Funding assumption used:

* 50/50 gf/fed split

** 100% gf

*** Federally approved cost allocation

Appendix 16

Five Year Trend

			1 -year	2 -year	3 -year	4 -year	5 -year
32 Bed Specialized Inpatient w/ 12 Bed ICU	*	$12,061,187	$12,941,654	$13,886,394	$14,900,101	$15,987,809	$17,154,919
32 Bed Specialized Inpatient w/ 8 Bed ICU	*	$11,393,745	$12,225,488	$13,117,949	$14,075,559	$15,103,075	$16,205,600
16 Bed Specialized Inpatient w/ 4 Bed ICU	*	$6,223,234	$6,677,530	$7,164,990	$7,688,034	$8,249,261	$8,851,457
4 Bed Intensive Care Unit	*	$1,715,725	$1,840,973	$1,975,364	$2,119,566	$2,274,294	$2,440,317
6 Bed Secure Residential	**	$1,176,557	$1,228,326	$1,282,372	$1,338,796	$1,397,703	$1,459,202
16 Bed Sub Acute Rehabilitation Program	**	$3,714,842	$3,878,295	$4,048,940	$4,227,093	$4,413,086	$4,607,261
Community Links Project	**	$100,000	$104,400	$108,994	$113,789	$118,796	$124,023
Legal Service	**	$300,000	$313,200	$326,981	$341,368	$356,388	$372,069
Transportation	**	$208,880	$218,071	$227,666	$237,683	$248,141	$259,059
Crisis Triage / Diversion Beds ($100k/bed)	**	$1,000,000	$1,044,000	$1,089,936	$1,137,893	$1,187,960	$1,240,231
Care Management	**	$275,000	$287,100	$299,732	$312,921	$326,689	$341,063

* Annual rate of growth: 7.3% - source: BISHCA

** Annual rate of growth: 4.4% - source: Consumer Price Index, 12th month, Medical Care

Appendix 17

VSH FUTURES TIMELINE: UPDATED JANUARY, 2005

NOTE THE TIMELINES REPRESENTED HERE ARE TENTATIVE AND MAY FLUCTUATE BASED ON THE FINAL direction of project, completeness of various permitting applications, the identification of willing town and/or hospital partnerships for land acquisition, construction money being fully allocated in either one or two fiscal years and that the preliminary project scoping and CON processes (which involves staff; advocacy groups and engineers) move along without a lot of controversy.

Milestones/Steps	Target date for Completion
Identify VSH Advisory Group as Primary Vehicle for Stakeholder Input • Expand role and membership & review planning steps • Regular meetings throughout planning and implementation process	On-going (semi-monthly meetings re: VSH Future since February, 2004)
Work with Legislature Oversight Committee	Established in FY04 Session On-going (at least 6 meetings / yr)
Identify & Clarify Target Populations for VSH services • Identify reasons for long timeframes for invol. med. Process • Meet with Corrections re: population overlap issues	Mid March 2004
Understand CMS regulations re: Structures for Alignment with Other Hospitals • Identify CMS requirements re: Governance • Explore other state examples re: state – private joint operations (Organizational alignments, staffing, governance, funding, risk management)	April 2004
Identify Possible Alignments with Other Hospitals and Community Providers • Develop all possible alignment configurations re: size, management, building ownership,	Mid-June

Milestones/Steps	Target date for Completion
state vs. private staffing • Work with Governor's staff and VSH Advisory Group to prioritize preferred alignment scenarios • Provide information to all Vermont hospitals and community providers; meet with interested parties to assess interest in potential alignment scenarios • Issue formal RFI for Inpatient and Alternative Services • Review Responses, incorporate as needed in draft plan for Secretary Smith	July – October August December 04 January 05
Explore Community Alternatives, Secure Residential Options • Final definition of target groups for services • Clarify function to be addressed (e.g., triage, diversion, rehabilitation) • Develop cost estimates (capital and operating) • Identify reimbursement mechanisms	August – December 2004 December 04– February 05
Develop Preliminary Recommendations on Facility and Alternatives Needs and Design Work with Governor's staff to develop capitol budget Work with the Legislature to refine plans	December, 2004 January 05 January– May 05
Coordinate w/Act 53 State Health Plan & Health Access Allocation Plan	July 2004 and on-going
Identify Program Approach for Housing Investments (group residential facility or individu **Housing subsidies)** **To create a Safe Haven Program or Shelter Plus Care with HUD funds** • Identify local host communities, work with local "continuum of care" to prioritize development with "bonus" funds • Gain state-level continuum of care #1 priority for bonus funds • Develop application in response to HUD NOFA • Secure Architect, space or land	April 05 May 05 June 05 July 05 December 05 – January 06 February – April 06 June 06 – March 07

Milestones/Steps	Target date for Completion
• HUD Notice of Award • Three month contracting period • Construction • Open Program for Residents	April 07
Meet with BISHCA to address CON work and steps for VSH	January 05 and on-going
Submit Outline of Replacement Plan to Governor and Legislative Oversight Committee	October 15, 2004
Submit Comprehensive Implementation Plan to Legislative Oversight Committee • Includes FY06 Budget implications for operating expenses	February, 2005
Legislative Authorization for Replacement Plan	cY05 legislative session (Jan – April, 2005)
Next steps will vary based on whether decision is to pursue hospital partnership(s) or stand alone construction	
Work with BGS on facility planning, design and costs	January 05 and on-going
Design RFP for Sub Acute Rehabilitation Programs and Secure Residential Services Issue RFP Review responses, select providers Develop contracts Program Development Close Brooks Rehab Unit/ Downsize Brooks I,II	February 2005 March 2005 May 2005 June 2005 August 2005- December 2005 January 2006-March 2006
Design RFP for hospital programs Issue RFP	May 2005 June 2005

Milestones/Steps	Target date for Completion
Review Responses, Select providers	August 2005
Develop Contracts	October 2005
Develop Care Management System	
Establish clinical and administrative work group	March 2005
Develop screening, triage, disposition protocols	April – July 2005
Establish participating partners and programs	July 2005– October 2005
Design management approach (traffic director)	October 2005
Pilot protocols	November – December 2005
Revise based on pilot	January –February 2006
Implement	March 2006
Design Voluntary Transportation System	March – October 2005
Create assessment protocols for appropriate transport (secure, voluntary)	April 2005
Design training for Sheriffs, Implement	June–September 2005
Develop voluntary transport system, RFP if necessary	July – October 2005
Pilot concurrent with Care Management Pilot	November – December 2005
Revise as needed and implement	March 2006
Design Triage/Stabilization Capacities	
Assess geographic need and develop allocation plan (e.g. number beds for NE Kingdo	July 2005
Identify local opportunities / resources	August–September 2005
Issue RFP	October 2005
Review responses, select providers	November–December 2005
Develop Contracts	January 2006
Program Implementation	April 2006
Develop Community Links or other Peer Program	
Issue RFI for Peer Programs	April 2005

Milestones/Steps	Target date for Completion
Review Responses, Select Provider Develop Contract Implement Program (s)	July 2005 August 2005 October 2005
Identify land to purchase if stand alone construction for Inpatient Services	Fall 2005 – Winter 2006
Public Process to Purchase Land for Hospital Expansion or Stand-alone Construction • Select board Meetings • Community meetings • Pre planning and zoning meetings	Spring 2006
Create Preliminary Building Design & Engineering Specs	Spring 2006
Submit BISHCA CON Letter of Intent Narrative summary of project including process and background info, services to be provided, area to be served (statewide or regional), estimate of amount to be expended (total cost)	May 2006
BISHCA Asserts Written Letter of Jurisdiction	June 2006 (within 30 days of receipt of letter of intent)
Engineering Drawings	June 2006
Begin Local Permitting Process	April 2006 (allow 4-6months)
Begin Act 250 Process	upon completion of local permits (allow 4-6 months)
Contractor Selected – (Building Process determined)	September 2006

Milestones/Steps	Target date for Completion
Submit Full Application to BISHCA for CON • Site and Architectural plans (schematic level) • Basic electrical and mechanical engineering details (schematic and/or narrative detail sufficient for BISHCA to rule complete)	No later than December 2006 (must be within 6 months of Letter of Intent)
BISHCA Requests Additional Information if needed	Dec 2006/January 2007 (15 days following submission of application)
Submission to & Review of Additional Information by BISHCA	January/February(4-6 months)
BISHCA Rules "Application Complete" and Issues Public Notice for Competing Applications, Interested Party Status or Amicus Curiae	March 2007 (notice must appear for 15 days in papers)
Public Oversight Commission Hearing Date Scheduled	May 2007 (30-60 days to get in schedule)
Public Oversight Commission Written Recommendation to BISHCA	June 2007 (30 days from hearing)
Commissioner BISHCA Makes Final Determination of CON	August 2007 (Within 120 days of date application ruled complete by BISHCA)
Ground Breaking/ Construction Phase	Fall 2007
Move In/Services Start Begin 0 reject admission	Fall 2008

Appendix 18

Process of Soliciting Feedback on VSH Futures Report

- Posting on Department of Health Website – www.healthyvermonters.info

- Public Hearing via Vermont Interactive Television at the following 13 sites: Bennington, Brattleboro, Johnson, Lyndonville, Middlebury, Newport, Randolph Center, Rutland, St. Albans, Springfield, Waterbury, White River Jct., Williston. (9 people attended)

- E-mailed a copy to the following organizations and groups:

  Mental Health Legislative Oversight Committee Members
  House and Senate Health and Welfare Committee Members
  House and Senate Judiciary Committee Members
  House and Senate Appropriation Committee Members
  Adult State Programs Standing Committee
  All Division of Mental Health & Vermont State Hospital Staff
  Alliance for the Mentally Ill – Vermont
  Designated Agencies ' Children's Directors
  Designated Agencies' Adult Outpatient Directors
  Designated Agencies' CRT Directors
  Designated Agencies' Emergency Directors
  Designated Agencies' Executive Directors
  Green Mountain Support Group
  Vermont Association for Mental Health
  Vermont Association of Hospitals and Health Systems' Inpatient MH Committee Members
  Vermont Coalition for Disability Rights
  Vermont Council of Developmental & Mental Health Services
  Vermont Federation of Children and Families
  Vermont Protection and Advocacy
  Vermont Psychiatric Survivors
  VSH Futures Advisory Committee Members

Summary of Types of Feedback Received

- Notes from the VIT Public Hearing
- Petition signed by VSH employees which states "We the undersigned request that the VSH Administration and the VSH Futures Advisory Group seriously consider the Vermont State Employees' Association's proposal to design and construct a "state of the art" State-run mental health hospital associated with a general hospital that would provide for a unified system of care."
- Minutes for the VSH Futures Advisory Committee
- Memo from Nicole Dewing, VSEA to VSH Futures Advisory Group re: The Future of VSH: State-operated vs. privatized function

- Letter from Anne Donahue to Charlie Smith, Secretary of AHS regarding information requested.
- VT Council of Developmental and Mental Health Services recommendation on the Future of VSH
- Summary of Informal Survey taken by Anne Donahue.
- From the VT Association of Hospital and Health Systems' Inpatient Mental Health Committee, a paper titled "The Future of Vermont's Mental Health Systems: A Statement of Vision"
- From Ken Libertoff, "Beyond VSH: A Roadmap for the Future"
- Over 70 e-mails from various stakeholders.
- Letter from CRT Directors responding to October 15th outline.

Discussions with:

- Nationally prominent psychiatric leaders
- Executive Board of the Vermont Psychiatric Association
- Hospital and Community Psychiatry Committee
- VAHHS Inpatient Committee
- Staff at VSH

Appendix 19

VERMONT

Department of Health *Agency of Human Services*
Division of Mental Health [phone] 802-241-2610
103 South Main Street • Weeks Bldg. [fax] 802-241-1129
Waterbury, VT 05671-1601 [tty] 800-253-0191
www.HealthyVermonters.info

Request for Information Regarding Possible Partnerships In a Transformed Mental Health System

December 16 2004

The Vermont Department of Health (VDH) is seeking partners to operate a continuum of recovery-oriented, community-based services including peer supports, acute non-hospital diversion programs, inpatient services including psychiatric intensive care, and sub acute rehabilitation services. This array of services will allow for the replacement of the Vermont State Hospital (VSH) as it is currently configured. All types of mental health service providers[1] are encouraged to respond to this Request for Information (RFI).

The objective of this RFI is to obtain information about partners to implement these services. Respondents should describe their capacity and interest to provide all or some of the specific service components in this RFI. This RFI is not a contract, implicit, explicit, or implied, nor does it imply any form of an agreement with any party. Responses to this RFI will be considered in drafting any Requests for Proposals for VSH replacement services.

The information gained from this RFI will be presented to the Vermont State Hospital Futures Advisory Group and to the Secretary of the Agency of Human Services (AHS). The responses will help inform the Secretary's recommendations on replacing the functions of Vermont State Hospital to the Mental Health Oversight Committee of the Vermont Legislature in January, 2005.

Please submit your response to this RFI in writing by the close of business on December 31, 2004 to:

Susan Wehry, MD
Deputy Commissioner of Health for Mental Health Services
Vermont Department of Health
108 Cherry Street
PO Box 70
Burlington, Vermont 05402-0070

[1] This includes hospitals with and without designated psychiatric inpatient units, designated community mental health providers, private mental health providers including residential and single or group practices, and advocate/peer service providers.

Electronic responses directed to WRichardson@vdh.state.vt.us and received before the deadline shall be accepted, as shall mailed responses postmarked on or before the deadline.

This RFI seeks information about the capacity and interest of partners for five distinct service components. ***Interested parties may respond to this RFI in its entirety or to any number or combination of the following components:***

- Peer support programs.
- Crisis stabilization/hospital diversion services.
- Acute inpatient care (involuntary) for civil and forensic admissions.
- Sub acute, longer term psychiatric rehabilitation services.
- Secure residential care.

Context for Replacing VSH Services

Replacing the current functions of Vermont State Hospital offers the opportunity to make new progress towards Vermont's continuing development of voluntary, community based services. However, VSH[2] currently provides the following safety net functions that are not duplicated by any other entity, and for which short and longer term replacement strategies may be required:

- A "no decline" admission policy.
- Acute, involuntary, inpatient treatment for individuals currently not able to be treated by designated[3] community hospital psychiatric units (by direct admission: 77 admissions in FY 2004; by transfer, 31 admissions in FY 2004).
- Provision of longer term (longer than one month), involuntary care for individuals with treatment refractory illnesses (60 percent of the bed days at VSH currently).
- Evaluation and inpatient treatment for individuals charged with a crime, also known as forensic evaluations (103 admissions in SFY 04).
- Provision of non-emergency involuntary psychiatric medication under Vermont's Act 114[4] (27 petitions filed in SFY 04).

The replacement functions for VSH, even in a transformed system of care, must address these aspects of a bottom-line responsibility for care. VDH believes that the current capacity at VSH, in community hospitals and with community mental health providers could be re-balanced across an array of inpatient, rehabilitation, and enhanced community resources to better meet the needs of Vermonters. This emerging array of inpatient, rehabilitation, and enhanced community resources must have sufficient "surge capacity" to meet expected spikes in demand, and must

[2] The Vermont State Hospital is currently licensed to operate 54 beds. In state fiscal year 04, VSH had a total of 219 admissions accounting for 18,963 patient bed days with an average daily in-house census of 46 individuals. Neither the Vermont Department of Health nor the Vermont State Hospital Futures Advisory Committee recommends a reduction in the overall system's bed capacity.

[3] A designated hospital is a general hospital with psychiatric inpatient services that is designated by the Commissioner of Health (formerly by the Commissioner of Mental Health) to provide treatment to individuals involuntarily committed to the commissioner's care and custody.

[4] Act 114 sets out clinical and legal standards, and the process for providing non-emergency psychiatric medications on an involuntary basis in a hospital.

function in a coordinated and statewide manner to accommodate the flow of patients across resources based on clinical needs.

In addition, AHS needs a psychiatric inpatient program capable of safely treating acutely ill and potentially dangerous individuals who are committed to the care and custody of the Commissioner of Corrections. This service would not be located within a correctional facility. [Neither the Department of Corrections (DOC) mental health units nor the VSH, as currently configured, is able to appropriately serve such individuals.] The DOC estimates that there are eight individuals at any given time in need of such services.

In choosing replacement services within the context of an evolving mental health service system, VDH will be guided by the following goals:

- To fully integrate the functions of VSH into local health care and community mental health (designated agency[5]) systems.
- To further the commitment to the principle of maintaining the locus of care in the community.
- To ensure that provided services are recovery oriented and trauma informed.
- To reduce the use of and need for involuntary care of all types, including inpatient.
- To ensure that all people with psychiatric disabilities, including those who are incarcerated, shall have access to high quality, clinically appropriate care across a broad continuum of services.

Guidance for Respondents to this RFI

Respondents to this RFI should describe how their proposed concepts for replacement services address the safety net functions and system goals listed above. In addition, respondents should address the following requirements common to all of the five service components:

- Geographic accessibility and decentralization of services. Multiple-site proposals are encouraged.
- Meaningful integration with general health care delivery is required.
- Meaningful integration with ongoing mental health care and community life is required.
- Patient access to adequate legal protections. Respondents should demonstrate knowledge of current Vermont law regarding patient's rights generally and involuntary care in particular.
- Programs and facilities must be flexible enough to accommodate future changes in treatment practices.
- Surge capacity is a necessary requirement of this system of care.
- Participation in a process of triage and placement involving other system components is required.

[5] A designated agency is a community mental health center designated by the Commissioner of Health (formerly by the Commissioner of Mental Health) as the lead agency to provide comprehensive services to Vermont's priority mental health populations: adults with severe and persistent mental illness, individuals with developmental disabilities, and children and youth with severe emotional disturbances.

- Each service component must be capable of identifying and effectively treating conditions that commonly co-occur with mental illness and among individuals seeking acute treatment including trauma, substance abuse, developmental disabilities, traumatic brain injury, and health problems.
- How both civil and forensic patients might be served.
- How the proposed approach to services would reduce the current demand for involuntary inpatient care.

Respondents to this RFI should describe their interest in and capacity to provide all or parts of the proposed service components. Finally, respondents are especially encouraged to address considerations that are not included in this RFI but which respondents believe should have been included.

Specific Service Components

1. Blended Peer Support Programs

In keeping with the vision of a community-based system in which all services are recovery-oriented, VDH is seeking both potential partners and design concepts for blended peer and provider service approaches. We are interested in how blended staffing in a wide variety of supports and services can support people in recovery and divert individuals in crisis from entering the hospital. We are interested in hearing potential partners' ideas about how to develop such resources and about more specific program characteristics for the following proposed components:

- Education and support resource centers.
- Crisis stabilization and inpatient diversion services.
- Sub acute rehabilitation services.
- Services that assist with the transition to community living.
- Approaches that reduce rates of involuntary care (both inpatient and community).

2. Acute Triage, Inpatient Diversion, and Crisis Stabilization (Capacity of 10 or more beds)

Triage, inpatient diversion and crisis stabilization services are needed. VDH is seeking both potential partners and design concepts. This need includes:

- An additional 10 or more crisis stabilization beds designed to divert inpatient admissions, to reduce length of stay for hospital care by offering a step-down[6] services and to provide a safe and supportive environment in which to assess what level of care is needed.
- Centralized care management capacity to manage the flow of clients among acute care programs, including entry into the system and disposition to appropriate levels of care.

[6] Step down means intensive, short term residential or partial hospital programs to provide treatment and facilitate return to the community from inpatient care.

- Safe and respectful transportation between acute treatment and stabilization program sites.

3. Involuntary, Inpatient Care (Capacity of 40 beds)

Psychiatric intensive and specialized inpatient care services are needed. This need includes acute care units for persons with mental illness whose behavior places themselves or others at very high risk for harm.

- 32 beds to replace existing VSH capacities.
- 8 beds to provide acute inpatient care for incarcerated individuals.

Two linked services are needed: a small (estimated 8-10 bed capacity statewide), intensive care program modeled after a medical intensive care unit (ICU), and a less intensive but specialized inpatient program (SIP) (30-32 beds statewide; ideally in two or more locations).

These services would have more security, specialization, and staffing than current Designated Community Hospital psychiatric units. Each service would work in concert with the designated hospital units, however, to triage patients across inpatient settings based on clinical considerations. These services would not turn away eligible admissions. These linked services (psychiatric ICU and SIP) should be provided in meaningful physical proximity to a general hospital and probably would contract for the sharing of diagnostic, lab, laundry, food or other required facility services.

- The needed 40 bed capacity (including ICU) can be provided in a single facility or in multiple, decentralized program sites.
- The inpatient capacity could be state-operated (if fewer than 16 beds), operated under the license of an existing hospital, or by a combination of such arrangements.
- Psychiatric inpatient beds would need to be less than 50% of a hospital's daily census to allow for participation in federal Medicaid.
- The service(s) must have the capacity to provide involuntary care, treat forensic clients, and administer non-emergency involuntary medications under the terms of Act 114.

4. Sub Acute Rehabilitation Care (Capacity of 16-20 beds)

Sub-acute psychiatric rehabilitation services with a 16-20 bed capacity statewide are needed. This component will provide intensive rehabilitation services to individuals requiring longer-term support but not inpatient-level care. As envisioned, this program would establish a new level of rehabilitation programming in Vermont's mental health service system. The capacity that would be provided by this component would be somewhat like that of physical rehabilitation programs in which individuals adjusting to catastrophic illness or injury receive intensive services to consolidate the gains made in inpatient care and to develop new skills to facilitate adjustment to their home environment. The programmatic orientation and staffing for this service should significantly reduce the need for involuntary treatment. Currently, all the

residents of the VSH "Brooks Rehabilitation Unit" are involuntarily committed to the VSH. A more decentralized, community-based, and recovery oriented rehabilitation approach may mitigate the need for involuntary treatment.

- The needed 16 to 20 bed capacity can be provided in a single facility or in multiple, decentralized program sites.
- The program(s) must be state-wide resources operating in collaboration with inpatient treatment and ongoing community care.

5. Secure Residential Care (Capacity of 6 beds)

Secure residential services in a community setting are needed. This service component will provide long-term services to individuals who are psychiatrically stable, who have committed serious crimes and who are in the care and custody of the commissioner. This residential program would provide supervision to ensure community safety, and the community's confidence in safety would be a high priority. The need for these services could be fulfilled by a single unit or by provision of wrap-around[7] services for individuals in separate locations.

[7] A wrap-around plan is the generic term for an intensive, individualized program of care, usually including support and supervision 24 hours a day. Each program is created for one person, based on that person's unique needs and strengths.

Appendix 20

RESPONSES FROM THE RFI

12/22/04

Susan Wehry, MD
Deputy Commissioner for Mental Health Services
Vermont Department of Health
108 Cherry St.
PO Box 70
Burlington, VT
05402-0070

Dear Dr. Wehry:

I am writing on behalf of the Counseling Service of Addison County in response to the RFI for the VSH Futures process. Our agency has been very interested in the Futures process and in the possibilities for innovation and improvement that this process invites. We are deeply committed to as complete a spectrum of integrated community based care as can effectively be developed and sustained, and to the values of respectful, effective, recovery informed care in the least restrictive environment needed. We are interested in participating in the Futures process especially in regards to strengthening our existing resource base of housing and crisis supports, and we believe that we could develop capacities that would reduce use of involuntary hospitalization. We are developing proposals to create capacities for Inpatient Diversion, Crisis Stabilization, and Sub Acute Rehabilitation for consumers in the Vermont system of care. We are also looking at possibilities to incorporate blended peer support into these or separate proposals.

The Counseling Service would bring to these proposals our commitment and values in regards to quality consumer driven services. We have consistently strong DBT and Recovery programs, a long standing commitment to welcoming, integrated co-occurring disorders services, and strong psychiatry and emergency teams. We are a comprehensive community mental health center with expertise and services for consumers who are coping with other conditions in addition to mental illness, including substance abuse, developmental disabilities, and trauma.

Given holiday schedules and the deadline for this RFI, we are unable to provide as much detail regarding these possibilities as would be desired for this stage of the process. Our initial thoughts are as follows:

- Long term supported housing has been identified as a priority need in our system of care. The development of such housing could allow for possible placement of VSH patients, and could take some capacity pressure off of Hill House which has had to serve needs that go far beyond its original design as a transitional residence.

- We are further considering proposing that Hill House develop recovery oriented programming, increase crisis stabilization capacity, and function as a transitional residence, stepdown, and stabilization program that could have some capacity for subacute rehabilitation referrals from the broader system of care.
- In addition to increased crisis stabilization capacity and services at Hill House, we are also seeking to further develop flexible outreach stabilization teaming, informed by the ACT model. We believe that these capacities would reduce the need for involuntary interventions.
- We are considering further whether to develop a larger scale proposal for acute stabilization and/or subacute rehabilitation, especially as there are some compelling buildings available in Addison county.

We welcome the opportunity to participate in the further development of community based services in the Futures process.

Sincerely,

Alexander Smith
Director, Community Rehabilitation and Treatment Program

Community Rehabilitation and Emergency Services
United Counseling Service of Bennington County, Inc.
100 Ledge Hill Drive, PO Box 588
Bennington, Vermont 05201
Phone: (802) 442-4968 Fax: (802) 447-1181

Response to Request for Information Regarding Possible Partnerships In a Transformed Mental Health System

United Counseling Service of Bennington County, Inc. would like to reply to the RFI issued by the Division of Mental Health on December 16, 2004.

The CRES Division of UCS is organized to provide the type of services essential to address the gaps in the public mental health system as it is currently configured and as anticipated through a reorganization of the function and services of the Vermont State Hospital. As the state hospital is reorganized delegation of a substantial portion of the safety net currently provided by VSH will be passed to the local and regional communities of Vermont. UCS serves the southwestern region of the state. Currently there are no inpatient psychiatric hospital beds in this area.

Crisis Stabilization/hospital diversion services

UCS provides crisis intervention, crisis stabilization and hospital diversion services through programs operated out of Battelle House. Battelle House provides six acute care diversion beds. These beds are available regionally to assist those in need of hospital diversion across the southern portion of the state.

The use of beds at Battelle House varies widely over time. For example, in March of 2004, bed use was at 89% of capacity; in April usage went down to 47.7% of capacity; and then in May usage rose to 91.2% of capacity. Currently we are at 47.4% of capacity (12/01/04 – 12/22/04). We believe it is possible to manage the use of those beds more efficiently through the wise provision of some additional clinical and case management resources. Currently we have a plan in place that relies upon workers providing per diem services when the milieu becomes stressful and non-therapeutic at Battelle House. Unfortunately this plan depends upon a workforce that is over worked and under supported. Through additional reliable and consistent resources we believe it is possible to improve the efficacy and efficiency of diversion services accessible to the southern region of the state, thus reducing reliance upon psychiatric inpatient beds.

We are able to monitor usage of crisis intervention and crisis stabilization services through a daily “disposition meeting” at Battelle House. This meeting helps us to monitor the services, but is short of the goal of providing important face-to-face time with the psychiatrist to improve the outcomes of crisis stabilization.

The CRES Division also provides direct medical services for CRT consumers with chronic medical conditions such as diabetes. We have employed a part-time “care partner nurse” who monitors vital health care indicators such as Hg-A-1c levels, blood pressure, lipids and triglycerides, etc. as well as providing education, support and hands-on health improvement skills. We have found that this service is essential to plan and prepare for alternatives to psychiatric hospitalizations.

Sub acute, longer term psychiatric rehabilitation services

UCS provides a residential program at the South Street Group Home. Currently the group home provides three congregate level beds downstairs, and a three-bed supported apartment program upstairs. Residents typically stay at the group home for one or more years. Staffing at the group home is provided by single-coverage 24 hours per day, 365 days per year.

We believe that is possible to improve the efficacy and efficiency of residential services through the provision of more person-tailored psychiatric rehabilitation and recovery services both for the residents of the group home and those persons transitioning out of the group home. These rehabilitation services may be provided in the same manner as the additional services needed at Battelle House, and they may potentially divert people from usage of group home services toward services provided in the community and in the home.

Additionally, we currently provide a small warm line service operated by residential staff. This service is being transformed into a consumer-operated warm line. Participants in the planning and implementation of the consumer-operated warm line also provide peer support groups in our CRT program. The coordination and support of these vital peer support programs is currently being improved and developed. These programs are currently blended into the professionally-staffed services provided by the CRT program, and improvement of this blending of services can only be accomplished through dedicated time and partnership. With the burden on the current workforce, this is difficult to accomplish and therefore the aforementioned additional staffing resources are essential to succeed in this endeavor.

Coordination of service availability

We have spoken with the Executive Director of HCRS, and we are aware of a growing interest among providers in the southern region of the state to coordinate services and provide an efficient seamless network of care. Our willingness to work with this group is essential to assure success in the provision of both diversion services and sub acute psychiatric rehabilitation

services. We envision a more responsive back door to services needed beyond the scope of our array as well as a more welcoming and available front door to our own system of care through a coordinated southern network. Such a coordinated and reliable system of care is essential to take on the future needs of a statewide system oriented toward a decentralized inpatient network and a more responsive local system of care.

SUMMARY OF UCS CAPACITY FOR EXPANDED LOCAL CONTINUUM OF SERVICES

1. **Crisis Stabilization/hospital diversion services**
    a. Serve as a regional resource for diversion
        i. Provide diversion beds at Battelle House – up to 30 days
        ii. Provide daily rehabilitation program
        iii. Resources needed:
            1. face-to-face access to MD or PA on a daily basis
            2. Care Partner Nurse
            3. diversion team including additional clinical services and case management services as well as blended peer support services

2. **Sub-acute, longer term psychiatric rehabilitation services**
    a. Serve as regional resource for step-down from diversion services
        i. Provide rehabilitation beds at South Street Group Home for up to 6 months
        ii. Provide intensive in-home rehabilitation for community living skill and resource development (some of the services that would have been provided through longer residence in the group home)
        iii. Resources needed:
            1. Ongoing therapy on an intensive level (2 or more sessions weekly)
            2. Case management support on an intensive level (3 to 5 visits weekly) to develop skills and resources needed for both intensive therapy and community living
            3. Coordination of medical health care through additional hours of the part time "care partner nurse"
3. **COMBINED SERVICES**
    a. Both of the services outlined above could be coordinated by an intensive unit of the CRT Program – combined resources would include additional hours of clinician availability and additional case managers working in consort with Battelle House, South Street Group Home and peer support programming.

December 30, 2004

Susan Wehry, M.D.
Deputy Commissioner of Health for Mental Health Services
Vermont Department of Health
108 Cherry St.
P.O. Box 70
Burlington, VT 05402-0070

Dear Dr. Wehry,
In my role as CRT Director here at WCMHS and on behalf of my colleagues at the Clara Martin Center and Northeast Kingdom Human Services I am writing to provide you a response to the RFI regarding the replacement for VSH. The three agencies have decided at the Executive and Senior Management levels to offer a collaborative response outlined in the enclose paper. This effort was one that came together very rapidly in the midst of the holiday season. Thus, while we have endeavored to provide the best answers to the Futures Committee and VDH concerns, we were not able to be as complete in all areas as we might have wished.

The agencies will refer to a shared title of Northeast/Central Collaborative or NCC in the response, however, we do not see our collaboration as static—i.e. we welcome participation from other D.A's and other entities who might be interested in the work ahead. In terms of contacting NCC regarding this proposal you may contact me at the number above, Cathy Rousse at NKHS, or Jeff Rothenberg at Clara Martin.

On behalf of NCC I thank you in advance for consideration of our proposal in the VSH replacement developmental process.

Sincerely,

Michael Hartman,
CRT/ICS Director

A Response
To the
Vermont Department of Health/Division of Mental Health
Request for Information Regarding Possible Partnerships in a Transformed Mental Health System

Submitted by
The Northeast/Central Collaborative:
The Clara Martin Center
Northeast Kingdom Human Services
Washington County Mental Health Services, Inc

Contact Persons:
Jeff Rothenberg, CMC
Catherine Rousse, NKHS
Michael Hartman, WCMHS

The "Request for Information Regarding Possible Partnerships in a Transformed Mental Health System" has led to a variety of discussions and meetings regarding how best to respond to it. These in turn have led to the formation of a tri-agency proposal by the Clara Martin Center (CMC), Northeast Kingdom Human Services (NKHS), and Washington County Mental Health Services (WCMHS). The proposal by what is now considered to be the Northeast/Central Collaborative (NCC) which follows outlines our combined vision of what services and facilities we believe can be provided by us, and other possible care partners, to meet the needs of the RFI put out by the Department of Health on December 16th, 2004.

Two agencies, CMC and WCMHS, have worked in tandem over the last 30 years to best serve mental health consumers in the Central Vermont area. These efforts most recently have included the contracted agreement between CMC and WCMHS to share resources to provide crisis services in the most economical model possible. Another example can be found in the creation of the Central Vermont Substance Abuse Services program that began through a joined effort by CMC, WCMHS, and the Howard Center. NKHS has not formally collaborated with either of the other agencies to provide ongoing services, but we have shared consumers across our catchment area boundaries. Also, the WCMHS and CMC CRT and Emergency programs have had positive referral and service experiences with the NKHS programs. As well, the former Developmental Services program director at NKHS, known as a strong collaborator with other agencies to provide quality services, has now become the Executive Director of the agency. Each of the agencies brings experience of collaboration with consumers, residential care, crisis intervention and diversion that compliment and strengthen the group as a whole. Thus we believe these working relationships can be extended to include some or all of the services needed as Vermont State Hospital transforms its role in the next 3-5 years.

While we have more experiences with some of the components than others we are interested parties in all of the service components. This includes being part of the solution to fulfilling the current state hospital's role of bottom line responsibility for care. We agree with all of the goals listed in the RFI, and believe we have a documented track record of meeting the goals listed:

- To fully integrate the functions of VSH into local health care (including local hospitals as they collaborate with NCC and DMH) and community mental health (designated agency) systems.
- To further the commitment to the principle of maintaining the locus of care in the community.
- To ensure that provided services are recovery oriented and trauma informed.
- To reduce the use of and need for involuntary care of all types, including inpatient.
- To ensure that all people with psychiatric disabilities, including those who are incarcerated, shall have access to high quality, clinically appropriate care across a broad continuum of services

While there is a need in all five of the counties represented by NCC for certain types of these service components we are interested in partnering not just in projects in our designated catchment area's but also especially those catchment area's that are adjacent to us. We believe that rather than create larger units, our area of Vermont would be better served in transforming the system by developing smaller units strategically and geographically positioned in the state

and working in collaboration to use all the area resources in the most efficient manner. This NCC proposal provides such a balance of regional collaboration while retaining local control.

The proposal as written seeks to address the following objectives:

- Serve persons who presently are inpatient in the Brooks Rehabilitation Unit of VSH.
- Provide services to divert proposed patients from hospitalization.
- Provide services to rapidly return persons who have been involuntarily hospitalized back to their local community.
- Provide services aimed at strengthening the recovery services for those who have been hospitalized via community supports to foster greater resiliency and ability to cope with crises.

Blended Peer Support Programs:
Both CMC and WCMHS have strong working relationships with Vermont Psychiatric Survivors and a record of peer provided services. WCMH has had a long standing consumer "warm line" and was one of the first agencies to have consumers working as peer support workers. CMC has partnered with Vermont Psychiatric Survivors (VPS) and NAMI - VT in the Safe Haven Program in Randolph, which is still the only such partnership in the country. Both these agencies had staff and consumers attend the recent trainings done by Mary Ellen Copeland on consumers working with individuals on Orders of Non-Hospitalization (ONH's). NKHS has not had an experience in peer supported services to the degree of the other two agencies, but has begun to move in this direction and is exploring how to best do so.

Any service component that we partnered with whether it be sub acute rehabilitation services, crisis stabilization services, inpatient care, and/or secure residential care would be encouraged to hire former or present consumers. The agencies would also be willing to explore the possibility of overseeing or consulting with other DA's or other entities that might be interested in the creation of new Safe Haven like programs, or the enhancement of programs that could serve a similar population. Our interest in this area is to support the development of programming that has been successful in our area.

Among the services currently provided by peer staff at either agency include:

- Staffing and support at the Safe Haven
- The Peer Line—a warm line available to WCMHS consumers daily from 6 – 11 p.m.
- Three 13 week recovery education series annually based on the Copeland model. This series is open to staff, any WCMHS consumers, and the general community as well.
- 1:1 tutoring on Recovery Education and individual WRAP development.
- Support and meals at a weekly soup kitchen in downtown Montpelier.
- Support for residential care at the Hillside Homes on Northfield St. in Montpelier.
- In home supports for grocery shopping, exercise, and general needs.
- Transportation and support for medical appointments
- Medication delivery and support.

WCMHS is following the lead of CMC in creating a working relationship with VPS that will see VPS peer's staffing WCMHS programs, the first of which is to be the Sunrise Recovery Center. Staff at Sunrise will be linked to those working at Safe Haven via VPS and will strengthen the supervisory capacity of VPS to support the staff working in Central Vermont. WCMHS expects to formalize the agreement with VPS regarding peer staff in early 2005. As mentioned previously NKHS is also pursuing the engagement of peers to provide key services as well.

Acute Triage, Inpatient Diversion and Crisis Stabilization:
WCMHS has been a leader in the Crisis Stabilization arena and reported to the VSH Futures Committee on the strengths of its current programs serving the VSH population and those who are diverted from it. In both Home Intervention (HI) and Chrysalis House programs WCMH is currently working with highly volatile consumers. At HI these persons are trying to remain in the community and avoid VSH or other involuntary care. At Chrysalis House we are transitioning persons with extensive histories of inpatient VSH care due to violent or destructive behavior. The Safe Haven program mentioned earlier also has a proven track record of transitioning individuals from different parts of the state from VSH. While NKHS has not operated a licensed mental health care facility, it has done so for the DS population for a number of years. As well the agency had some of the first community crisis diversion homes in the state using Short-Term Beds or STB's to do short term crisis assistance and diversion for consumers. NKHS also has been formulating plans for the creation of some facility based services for the last year and has been in discussions with the Northern Vermont Regional Hospital (NVRH) to create some more developed residential crisis options.

All programs referred to above have accepted admissions from other areas of the state, and would continue to accept such. We would see in the current planning, however, an opportunity to assist in either establishing such services in other areas and/or enhancing our current services to increase the acuity they might serve. We would advocate for the building of more of this type of beds either tied to a sub acute rehabilitation unit or as stand alone components.

At this time we could foresee at least two possibilities in this area. First that CMC has begun to explore the use of a site with access to a healthcare provider that would accommodate a Specialized Rehabilitation Unit and/or a crisis stabilization program. This could allow for ongoing and crisis level care in an area triangulated between Barre, White River Junction, and St. Johnsbury.

A second proposal is also related to a new Specialized Rehabilitation Unit, that WCMHS would relocate HI to be a joined location with this new service, probably in the Berlin area. The level of care at both facilities could be enhanced by co-location allowing for more efficient use of medical staff—Psychiatry, Nursing, and general medical needs. This would increase the ability of HI to accept persons who might require some nursing oversight on a 24-hour basis, and support the same for the Spec Rehab Unit. In both facilities under current VT Nursing Board regulations, the administration of medication and the writing of newly prescribed medication, including PRN's must be overseen by an RN. Co-location of these facilities would allow for this level of care and reduce the cost for it by sharing between the two facilities. We have had initial

conversations with local medical providers and a possibility of locating a general practice at this site as well would provide overarching medical care to persons at HI or in the Specialized Rehababilitation facility. This is a complicated scenario, but it does appear worth further exploration.

As mentioned previously, NKHS has engaged in discussions with NVRH to explore the use of the former Founders Hall space at the hospital as a crisis diversion or residential space. The current space could easily accommodate up to 6 persons and would be located within NVRH, thus having immediate access to medical care as needed. Any of these kinds of facilities could be run by individual agencies or NCC as a whole and/or with other partners, including the state if there was interest in doing so.

In terms of capacity it is clear that enhancing and relocating HI would increase the acuity that could be managed there and perhaps the number of beds by one or two. Chrysalis House currently has two residents in it, but within the two to three years for the VSH replacement to take shape, it is likely that two more residents could come into that program. The creation of beds in the St. Johnsbury region would be at least 6, but it is likely that more could be accommodated to also include the ability to manage persons with co-occurring disorders who might need to be in close proximity to a medical facility. Thus the number of diversion/stabilization beds could increase by 6-10 beds minimally.

NCC would also be interested in the: "Centralized care management capacity to manage the flow of clients among acute care programs, including entry into the system and disposition to appropriate levels of care." This would obviously involve working with the state and all of the other partners in the transformed system. We are especially glad to see this specifically mentioned in the RFI, as a concern for "managing the flow" of people through the system is strongly shared by all agencies. All the agencies are very familiar with Vermont law regarding patient's rights and involuntary care and would want to see clear rules, policies, and protocols for such a system and adequate legal protections for consumers at all parts of the system.

An especially important part of this management should involve the non-CRT enrolled involuntary patient. We would be very interested in pursuing the linking of immediate, but brief, therapeutic, case management services to these consumers. All the agencies have worked stridently for a number of years to reduce their use of VSH and to move persons hospitalized out of VSH as quickly as it is advisable to do so. We believe the creation of such a case management service to non-CRT consumers who are from our catchment area's and are hospitalized elsewhere and possibly non-CRT admissions to the CVMC Psychiatric Unit could reduce the Length of Stay (LOS) for these persons. This would be accomplished via diversion from a possible step up to a higher level of care—i.e. VSH or its replacement—and/or decrease the LOS of those persons thus creating more capacity at the DH's and VSH or its replacement.

The model for this brief, therapeutic case management is based in the ACCESS program at Washington County Mental Health, based in their Emergency Services Division. For nearly a decade this program has provided this type of service for children and adolescents, winning high praise from both inside and outside of the Agency. The Collaborative would propose the use of a

similar model for the area we serve, and would be willing to expand beyond those boundaries as might be desired or seen appropriate by DMH.

In terms of operation such a model could be run in tandem with those services currently performed by the DMH Care Managers, or a new system could be created, but a private/public model would likely have the greatest ability to manage cost and capacity. Regardless of the mix of funding or staff, NCC will exhibit an ability to triage, place consumers at optimal care levels, and then move them into or out of intensive care environments as such a diverse system of care will likely be more in need of such management than ever before.

The transportation of consumers across the newly created system of care is one complicated by what legal authority is bestowed upon providers. At present the movement of involuntary patients has been via law enforcement, ambulance, or once admitted, by VSH staff. It is clear that one aspect of concern expressed regarding transportation is how to make the process one that is not inclusive of anymore restrictive management than is necessary—e.g. handcuffs, or mechanical restraint—and is least trauma inducing. NCC supports the safest and most humane transport methods; however, we have had little time to develop a clear proposal. Thus, we can only offer a clear commitment to honor these areas of concern.

Involuntary, Inpatient Care:
The Acute Care model requires the commitment of a general hospital to be a partner in accordance with the Futures Committee statement of co-located care. At present we have not had formal discussions with any hospitals in our regions regarding this, though we are involved collectively in different projects with Central Vermont Hospital, Gifford Hospital, NVRH, Dartmouth Hitchcock Alliance and the VA Hospital. We are willing to be a partner in such a venture; however, this will require more time than is available to do so for this RFI. As well, we do also support a partnership with other DA's to create such a unit for the Central or Northeastern areas of the state, however, again more time would be needed to have a sense of how that could develop. One question we would propose to the Committee is whether the availability of health care through an existing FQHC or other community-based provider could be considered. We are a bit confused regarding some level of dissonance between the support for more community based mental health care, but a stipulation that it is provided within the context of a institutional based system.

The need for forensic evaluation was discussed extensively during the VSH Futures Committee meetings. NCC has not had adequate time to develop a strong proposal in this area and concerns about public safety and perception of such permeate this aspect of the VSH replacement. We are continuing to work to develop concepts, however, it is likely this would require significantly new skills and partners for NCC and its components, thus more extensive preparation is needed.

It has been discussed that there is a need to have persons in need of forensic evaluations placed elsewhere than VSH or its replacement. Given the information supplied by DMH that a portion of these referrals are seen as competent and therefore in need of treatment, we agree that hospitalization may not be the most appropriate level of care. We are willing to work in partnership with DMH to determine how to assist in this area, though the question remains as to how to best accomplish this.

As mentioned previously NCC is willing to work in tandem with any sites to best manage capacity issues for these units. This would hold true even if the units were not in our region, and our efforts would include creation and establishment of relationships with local courts regarding best service for involuntary forensic patients, while maintaining a system that can absorb all new referrals concurrently.

Sub Acute Rehabilitation Care:
As mentioned previously NCC has a clear interest in the operation of a psychiatric rehabilitation unit as described in the RFI, in partnership with the state and possibly local hospitals and/or other Designated Agencies (DA's). Our preference is to support the concept of expanding localized treatment access, thus we would propose the operation of up to two, 8 –10 bed units for long term rehabilitation patients from the acute care units established in replacement of VSH. We would be especially interested in partnering around one of these units for the North / Central part of the state. We are exploring the possibilities mentioned above as one of the sites for an 8-10 bed unit. All of these sites would be quite accessible to persons in the Central and Northeastern parts of the state, and for most of the remaining areas except for the most northwestern and southwestern areas.

The sites would incorporate access to medical care as needed either through local health providers, or through a general hospital. In all sites the agencies have historically good working relationships with health providers and would be able to construct healthcare arrangements as the project develops.

We do support the concept of these units as non-hospital alternatives, but do believe that certain standards of care as defined by the Licensing Division of DAIL for either a Level III care home or a Therapeutic Community Residence (TCR) should be employed. This unit would serve as a program operated in concert with the VSH replacement hospitals and be solely used for that purpose—i.e. direct referrals from the community or non-VSH replacement hospitals would not be accepted.

Regarding the Specialized Rehabilitation Unit in either location discussed above the number of beds would be 8-10, though both units could be utilized for up to 20 beds overall.

Secure Residential Care:
Regarding the residential forensic program for persons deemed in need of care, but no longer require a hospital level of such we again have not had time to reach a sense of clarity. Currently WMCHS has admitted into CRT two persons from VSH who had such histories, and CMC is currently doing so with another consumer who while not technically on a forensic status, presents with many of the same issues NKHS has also taken forensic VSH patients into the community and provided secure care. NKHS has also had long running residential services for sexual offenders that have a substantial positive record.

Many of the current models serving forensic and at risk offenders in Vermont utilize a model of wraparound for one or two offenders with significant staffing. NCC would support consideration of this model, and within our current experience believe we could provide this type of service.

Though we have willingness to address how best to serve all the stable VSH forensic population a concrete response was not possible within the tight frame of the RFI. It seems likely that an attempt to create a TCR like residence for this population could face significant challenges from communities. We philosophically believe strongly though in individual placements in the community as being in line with the systems values and beliefs about individualized care, close to home communities, reducing stigma etc. However this sort of initiative is going to need to be more clearly thought out with strong support from the state on whatever model is chosen for this component. Thus, we would want to have greater clarity on planning for this type of programming.

Administrative and Clinical Considerations

As stated in the November 30, 2004 Memo to the VSH Futures Committee from the CRT Directors the NCC supports the concept of private/public partnerships regarding replacement of VSH. This would entail a defined relationship with DMH, the DA's involved with this project, and any general or designated hospitals who wish to be a part of the system of care. This also includes setting clear benchmarks for outcomes and how failure to meet them would be addressed, but also included is the financial commitment that a plan followed is a plan funded. Unlike the often quoted history of ever decreasing state support following the closure of the Brandon Training School we expect that the state will honor the need to adequately fund this and other proposals to replace VSH. To foster such commitment the collaborating DA's seek a clear partnership with DMH that entwines all parties in the financial and management risks of a new model of care.

In the clinical realm we also support those concerns stated in the Memo regarding best care in a new model. These include:

- Significant flexible structure of care—especially at the crisis level—that allows for maximum consumer choice versus strict recipe programming
- Recovery education and principles need to be incorporated at all levels of treatment.
- Significant clarity should be established on what standards consumer/patient choice, participation, and collaboration are to be judged. We strongly support a model of maximization of consumer/patient collaboration that would encourage a realization of choice for what direction treatment can take.
- Families and other support persons from a patient's life must be creatively and openly encouraged to participate in the inpatient treatment.
- Co-occurring disorders and trauma informed care are also seen as major clinical components. All programs and all staff in those programs should exhibit their treatment approach concerning these areas and how they will maintain those components and train staff to them.

A significant concern of the NCC is how to manage issues of liability and the real cost of providing some of the proposed services in a new, community based setting. We are assuming that DMH/VDH will be willing to explore how best to partner on this issue to help facilitate community based care.

Resources

NCC recognizes that a number of resource issues will be faced in attempting to reduce the institutional based services of VSH. Some of these issues are very concrete—e.g. the creation of psychiatric time to oversee the care at a new HI or Specialized Rehabilitation facility. Other issues are somewhat less tangible, but no less needed--e.g. zoning exemptions that would allow for a secure facility in a town if it had 6 beds or less. This type of assistance has been provided in the past, especially in the case of the closure of the Brandon Training School, and greatly assisted in the establishment of community based resources. (Please refer to V.S.A.; T. 24; Ch117 (d) for further information regarding this specific example.)

Another very highly needed resource for this effort will be Information Technology (IT) services. The need for efficient communications of operational capacities and information sharing will be a key to the success of community based care. The moving of care from one central facility to a variety of sites across Vermont will require extensive IT resources to work effectively. Our respective agencies will continue moving toward improvement of our IT resources, but it will be extremely helpful if DMH can identify what targets might be helpful regarding this area so that NCC and other partners can try to move toward those as well.

Civil Rights

The NCC shares concerns that have been expressed by some members of the Futures Committee regarding access to legal services and protections. Given that consumers, once admitted as involuntary patients, lose a number of civil rights NCC strongly supports any effort to improve access to counsel and advocacy.

Funding

The NCC is concerned that any model ultimately chosen by the Futures Committee, and subsequently invested in by the state be one with adequate funding guaranteed. Though the entire system will no doubt be challenged by funding issues in the years ahead, persons who are involuntarily held should be guaranteed adequate and safe treatment. To suspend the civil rights of the patient is potentially a life-altering event for them. This effort must be allowed to occur without cutting corners thus compromising safety or respect in favor or saving dollars.

The NCC agrees and supports the statements made repeatedly by AHS Secretary Smith and Deputy Commissioner Wehry that start up and other funding to establish this new system of care will be granted through new funding, not be carved out of existing service budgets. This effort must be supported through the extension of funds to allow for community services to begin while existing hospital services still remain in place.

Community Safety

The NCC actively supports all efforts to educate the general populace on the mental health needs of its members and with the need for the safety of the public, as well as patients and staff. Concurrently we recognize that communities must cope with the acceptance of persons who are involuntarily treated within their own neighborhoods and a venue need be established that supports such a dialogue.

Current VSH Employees

The NCC shares concern about the employment of the skillful workforce that is now in place at VSH. VSH staff has helped a great number of Vermonters at their greatest moment of need. They have risked insult and assault upon their person to do a job that is complicated by knowing that when patients are the most symptomatic they will be challenging. Given the level of effort by the employees the Collaborative supports all efforts to ensure that a model that reduces employment and/or location of worksite has to also fairly address how these employees will be given an opportunity to continue their work, or transfer to work in such a way that respects their commitment to the citizens of Vermont.

December 31, 2004

Susan Wehry, MD
Deputy Commissioner for Mental health Services
Vermont Department of Health
108 Cherry Street
PO Box 70
Burlington, VT 05402-0070

Dear Dr. Wehry:

The Howard Center for Human Services (HCHS) was pleased to receive the "*Request for Information Regarding Possible Partnerships in a Transformed Mental Health System*" dated December 16, 2004. At a time when the economic, clinical, and contextual framework for providing and funding services to adults with serious and persistent mental illness is undergoing significant internal and external need for review and reform, this methodology for engaging and seeking input from multiple stakeholders in advance of and in preparation for the upcoming legislative dialogue is appreciated. As I am sure you can imagine, however, the timing to generate a meaningful and coordinated response during the last two weeks in December is challenged by the absence of so many during the holiday season. That limitation noted, and to the extent that we have been able to reach out and discuss among staff, managers and local stakeholders the issues raised by the RFI , we would like to offer the following comments for your consideration.

At the outset I would state emphatically The Howard Center's sincere and significant interest in entering into substantive discussions about an expanded role in Chittenden County in operating and/or partnering to operate an enhanced continuum of recovery-oriented, trauma informed, community-based services across the spectrum that would permit the replacement of the Vermont State Hospital (VSH) as it is currently configured. That said, and not unlike the letter you received on 16 December, 2004 from Dr. Robert Pierattini, MD, Clinical Leader and Chair FAHC Psychiatry Service on behalf of Fletcher Allen HealthCare our interest and ability will be more or less, dependent on the Division of Mental Health's (DMH) final position with regard to a number of structural, legal and economic parameters.

- How does DMH currently envision the management of economic and clinical risk in each or all of the proposed programmatic components? The recent crisis at VSH during this past year was noteworthy for, among other reasons, the State of Vermont's rapid infusion of dollars to increase staff salaries, address operational deficiencies, and substantially expand staff resources to address the noted deficiencies and needs. Though expecting proposed and planned community-based alternatives to the current VSH configuration to be well considered and avoid such pitfalls, what role would DMH and The State envision were such challenges to emerge in the provision of services by a community-based provider? Without wishing to dredge up failures of the past unnecessarily, when the State closed Brandon, community-based providers were then encouraged to offer more humane, clinically sound, economically advantageous solutions to move residents out into the community in exchange for which the state assured continued and sufficient

funding. As I am sure you know, the fiscal challenges facing Developmental Disabilities service providers in the upcoming funding cycle appear to be anything but consistent with that promise.

- Any proposed statewide community-based system will require an inordinately high degree of coordination between providers, the recovery community, local government and community and, here in Chittenden County, Fletcher Allen HealthCare. While we have not yet had detailed conversations with FAHC we have broached the idea and could envision the development of a model in which shared (for example, between HCHS, FAHC and Vermont State Employees) medical, case management, and nursing resources were structured in such a manner as to support client/patient movement through levels of care (e.g. inpatient, sub acute, crisis stabilization, residential) with consistency of built-in peer supports and a minimum of "new" staff handoffs. The HCHS and FAHC currently collaborate and share staff/resources in several high profile clinical services (e.g. Mobile Crisis, The Methadone Clinic, Act-I/Bridge) which could serve as a template for expansion into enhanced continuum of care modeling here in Chittenden County.

- Minimum VSH hospital-based bed capacity must be maintained at no less than the current levels. Though step-down and sub-acute services expansion as well as enhanced peer services models, over time, may demonstrate an ability to reduce such capacity, it would be premature in the planning stage to construct a service model on an unproven assumption. That said, on Page 3 of the RFI the necessity for 8 Department of Corrections (DOC) beds is highlighted. Since these beds are not now part of the 54 VSH beds, is DMH proposing consideration of a model that would establish 62 beds system wide? Or is DMH expecting that the developed system will have 8 less beds than current capacity to accommodate a population shift to satisfy the current unmet need of DOC? Clarification here of DMH's position is critical.

- A shift from a centralized state-operated facility with a "no-denial" policy to community-based beds with a similar expectation will necessitate a needed review of the philosophy of service offered throughout the state. Our experiences as a provider of crisis assessment and referral as well as post inpatient case management would suggest that significant change will be necessary in order to actualize an efficient system that is not confronted with patients in need of voluntary or involuntary admission and bed-based providers unwilling to accept them.

- On Page 4, the seventh bullet, the RFI highlights the broad range of clients expected to be served by the "transformed system." This listing appears to represent a significant expansion (with regard to TBI, DD and, to some extent, trauma) of populations currently served at VSH. The issue/challenge/opportunity to serve these populations is not, be definition, the problem. Rather, such expansion appears to highlight the need for clarity with regard to the resource allocation and distribution methodology given the current practice that links diagnosis with how clients are served and funded. As you know, adults with SPMI are funded through the Medicaid Waiver Case rate system, while clients in the DD populations are served on an individual waiver basis. Will the change in modeling capacity necessitate changes in either or both waiver models? Will funding for all

clients/patients be consistent across diagnostic categories? And, perhaps at the root of these questions, Is it the state's intent to conform the developed model to the existing waivers or to develop a desired model and then seek the (if) necessary amendments to the waivers?

- Chittenden County is the only real urban center in the state. It is likely that dispersal of the VSH caseload (as a result of acute admissions and subsequent case management, medical oversight and housing needs) will disproportionately have a greater impact on the greater Burlington area. Earlier reductions of VSH census demonstrated this trend in Washington County. Similarly, "*A Study of Detention in Vermont*," December 30, 2003 by The Department of Corrections noted that (based on 2001 population estimates) Chittenden County had 24.3% of the state's population but 34.9% of detention days. Any change in the location of VSH beds will no doubt exacerbate an already critical problem in housing in the Burlington area. Supervised apartments, shared-living arrangements, group homes, transitional housing and community-care homes are all inadequate to meet the current need and contribute, in no small part, to the "back-up" in the movement of clients throughout the system. Any transformed system must address this end of the service spectrum with the same vigor as acute bed access.

The Howard Center, a part of the not-for-profit designated community mental health system, has demonstrated a level of clinical and programmatic excellence, as well as fiscal accountability, in the development and delivery of services across the community-based spectrum: Programs such as the Next Door Program (Sub-acute/), Assist (Inpatient Diversion), Westview (peer-mediated vocational services), Lakeview (Community Care), 72 (Supervised living), Arroway (Group Homes), and CODTP (co-occurring treatment program), as well as taking the lead in integrating recovery, substance abuse and trauma informed services across Case management and facility-based programming. We believe that the current plan to reorganize where and how services are delivered offers an opportunity to enhance what and how we meet the needs of consumers and our community by further developing clinical and economic impacts for:

- Expanding the Assist program from 4 to 10 beds
- Replicate the Next Door Program as a non-transitional alternative
- Expand Lakeview Community-Care Home capacity
- Add additional peer-mediated supervised living alternatives
- Expand vocational integration to maximize community re-entry
- Integrate staffing with FAHC inpatient services
- Greater integration of trauma, substance abuse, & recovery modeling

We expect that after consideration by you and your staff, the VSH Futures Committee, The Secretary of The Agency of Human Services, and the Mental Health Oversight Committee of the legislature a Request for proposals (RFP) will emerge that will accurately reflect what is envisioned to be needed and what must be sufficiently funded. And, that the existing designated hospitals and designated community mental health centers across the state, as not-for profits with a demonstrated and successful history acting on behalf of the state, will preserve, expand and establish viable models of cooperation and integration that takes full advantage of the strengths

of their respective systems in the interests of enhanced services to consumers, their families, and our communities.

Sincerely,

Robert W. Bick,
Director, Adult Behavioral Health Services

January 3, 2005

Susan Wehry, MD
Deputy Commissioner of Health for Mental Health Services
Vermont Department of Health
108 Cherry Street
P.O. Box 70
Burlington, VT 05402-0070

Dear Dr. Wehry,

Attached please find Springfield Hospital's response to the Department's Request for Information dated December 16, 2004.

We are currently developing facility, program, and staffing plans which will be incorporated into a formal proposal pending receipt of the additional information requested through VAHHS on December 15, 2004. I am confident that both our proposed capital and operating costs will be very competitive.

Springfield Hospital looks forward to working with the Department and other interested parties in assembling the envisioned VSH replacement system.

Sincerely,

Glenn Cordner
Chief Executive Officer

GC/cs

Enclosures

SPRINGFIELD HOSPITAL

RESPONSE TO
VERMONT DMH RFI
FOR
VSH REPLACEMENT SERVICES

Overview

The Springfield Hospital has a long-standing commitment to providing high quality psychiatric services to the most seriously mentally ill individuals in the state of Vermont. This has occurred directly through the following Springfield Hospital services:

The Windham Center inpatient program
The Psychiatric Partial Hospitalization program
The Dialectical Behavioral Therapy intensive outpatient program
Buprenorphine Clinic services
Co-occurring Disorder capable services throughout the continuum
Springfield Hospital Emergency Room services

In addition, Springfield Hospital has developed this commitment through collaboration with HCRS in the provision of psychiatric crisis services, and in the elaboration of a continuum of care involving hospital alternative services and CRT case management.

Further, Springfield Hospital has established itself as a partner with Vermont DMH in the development of designated acute care services in general hospitals, and was the first community hospital in the state to accept patients on involuntary 72 hour hold status. In addition, Springfield Hospital piloted consumer satisfaction surveys provided by Vermont Psychiatric Survivors, and was the first hospital to have all staff participate in Recovery Training by VPS.

In this context, Springfield Hospital continues to wish to play a significant role in partnership with Vermont DMH in developing an appropriate array of community based alternatives for individuals currently receiving services at the Vermont State Hospital.

This proposal includes a range of possible options, in response to the possible needs outlined in the RFI. They include: Expansion of acute intensive care and general acute inpatient capacity at the Windham Center; expansion of capacity in the Windham Center continuum of care (partial hospitalization and DBT); expansion of crisis diversion and med/psych capacity at the Springfield Hospital; collaboration with HCRS and others in the development of crisis step-down capacity and sober supported housing to support a continuum of care; and clinical and management consultation services to any community hospital without inpatient psychiatry experience that wishes to provide VSH replacement services.

Acute Inpatient Expansion:

The Springfield Hospital proposes to expand its existing Windham Center bed capacity to 24 beds, increasing average daily census by approximately 6 (the maximum that can be accomplished without risking IMD designation problems), and adding 5-7 of the existing beds to the mix, to dedicate 12 of the 24 beds to VSH replacement capacity.

These beds would be developed in the existing building in Bellows Falls, by expansion into available space on the same floor, with additional office space on the lower floor. This will significantly control capital costs in the expansion, since the building (the former Rockingham Memorial Hospital) functioned as inpatient space in the past. The floor plan would be designed to incorporate both an intensive care capacity and a "normal" acute care capacity in two wings with a substantial proportion of single rooms and a common nursing station, to allow for maximal flexibility in assigning patients. In addition, enhancements in staffing and provision of on-site security around the clock would permit accepting the full range of patients regardless of acuity, and would permit accepting patients who required Act 114 involuntary medication, as well as seclusion and restraint (which we have used very sparingly and will continue to make every effort to use minimally). Further, the building already has on site urgent care, and procedures for access to all necessary medical services; this will be expanded with on site physician or physician assistant capacity dedicated to the inpatient unit, as well as expanded capacity for access to laboratory and other testing under the aegis of the Springfield Hospital. Finally, the flexibility in space would permit not only work with the most severely acute patients but would allow for the capacity to work with patients who required a longer length of stay for hospital level rehabilitation (we already have experience with some severely ill patients who have required acute stay up to 70 days), particularly for those who might benefit from co-occurring substance abuse treatment and/or DBT.

In addition, the Springfield Hospital pledges to have at least one bed always available for surge capacity requirements, and will develop clearly articulated policies and protocols to ensure such availability at all times. Some of this capacity will be linked to additional capacities listed below.

Continuum of Care Expansion

In addition to the above, Springfield Hospital will expand capacity in its existing partial hospitalization, intensive outpatient program, adult outpatient services and DBT programs to provide a broader continuum of services to these additional patients with significant needs. Additions will also include incorporation of more extensive co-occurring substance abuse services in all levels of the continuum.

Expanded Capacity at the Springfield Hospital location

Springfield Hospital is evaluating expanding capacity as part of this project in two major areas. First, Springfield Hospital proposes to develop secure space within the hospital to provide 23-hour emergency holding bed capacity to facilitate hospital diversion and to permit more ability to manage surge capacity needs. Second, Springfield Hospital will explore developing 4-

bed secure med/psych capacity in the medical part of the hospital in order to accommodate any patients with both severe psychiatric and severe medical acuity. If this expanded capacity is used even at 50% occupancy, this will expand Springfield Hospital's medical census, and thereby permitting a higher psychiatric census at the Windham Center campus.

Collaboration with HCRS to develop Hospital Alternatives

Springfield Hospital will work in collaboration with HCRS to facilitate hospital diversion and movement of patients through the hospital continuum. This will involve, first, developing a collaborative plan to expand the capacity of residential programs to function as a hospital diversion program on referral from the 23 hour holding bed, or as a step down from the inpatient unit, to facilitate access for more acute patients. This will incorporate capacity to combine these residential needs with Partial Hospitalization and/or DBT, as well as to provide specialized co-occurring disorder treatment.

Second, Springfield Hospital will work with HCRS and others to develop community supported sober housing for individuals with significant psychiatric and substance use disorder co-morbidity who need a safe living environment combined with access to partial hospital or outpatient support for continued sobriety.

Third, Springfield Hospital will work to expand its existing collaboration with the HCRS crisis team to be able to manage acutely and severely mentally ill patients successfully throughout the continuum of care provided by the Windham Center and HCRS.

Clinical and Management Consultation to other hospitals

Recognizing that there may be hospitals with little experience in psychiatric acute care who may be interested in providing licensed beds to assist in the VSH Replacement effort, Springfield Hospital is willing to offer psychiatric clinical and management consultation to assist in the development of a successful program in those settings.

Financial and Space Analysis

As part of its commitment to the design of this proposal, Springfield Hospital has engaged Public Consulting Group of Boston, MA, to undertake an initial feasibility and design study of both the financial and space elements supporting the above proposals. This initial feasibility analysis has created a framework for how to expand census within the IMD constraints, and provided an initial outline for how to use available space to construct the model of service being proposed. Further and more detailed analyses will be conducted once more information is provided concerning the nature of the population and the expected surge capacity requirements.

August 27, 2004

Susan Wehry, MD
Deputy Commissioner for Mental Health
Department of Health
Division of Mental Health
103 South Main Street – Weeks Bldg.
Waterbury, VT 05671-1601

Dear Dr. Wehry,

I am pleased to respond to your letter of August 20, 2004. Springfield Hospital has a long history of successfully operating a community-based inpatient and outpatient psychiatry program which is highly regarded by patients, patient advocates, referring practitioners, payers, and regulators.

Of our 69-licensed beds, 20 are dedicated to our psychiatric program, The Windham Center for Psychiatric Care, which also includes a partial hospitalization program with an average census of about six and a DBT program with a current census of ten. We employ three psychiatrists on our active Medical Staff. We were one of the first community hospitals to be certified to provide 72-hour hold involuntary care and one of the first to be permitted to provide involuntary care beyond 72 hours. We also provide a contracted one half to one day per week psychiatrist service to inmates of the Southern Vermont Correctional Facility in Springfield.

We are proud of The Windham Center Program and very committed to its important work. Philosophically, as I am sure the Division staff will testify, our desire has always been to be a willing and cooperative partner in helping to do what is needed to be done and doing it well.

At this very important juncture in planning the future of psychiatric care in Vermont, we are again eager and willing to play an important role in both planning the system and being part of it. At this early stage, I would enthusiastically offer our resources and expertise in any way you wish to enlist us and we would be open to considering any role for which a community hospital is a desired partner.

As you know, operating under our own hospital license, we have limited capacity for more psychiatric inpatients (about six, I believe) before we would hit the IMD threshold. We could add those and reconfigure the total to provide more system value in the current environment, or we could provide contracted program management to a unit licensed under another provider.

In conclusion, we have an excellent history as a provider, we are a cooperative and willing planning partner, we are very interested in expanding our role as a provider, and we are flexible as to the model and design in which we might work. We look forward to working with you and your team.

Sincerely,

Glenn Cordner
Chief Executive Officer

GC/cs

cc: Bea Grause, Hospital Association
Dr. Paul Jarris, Commissioner, VDH
Beth Tanzman, Director Adult CMH Programs
Tom Simpatico, VSH Medical Director
Ken Minkoff, MD, Consulting Medical Director, Windham Center
Chris Lorbati, MD, Medical Director, Windham Center
Janet Harvie, RN, BSN, Director of Patient Care Services, Springfield Hospital
Jim Walsh, RN, Nurse Manager, Windham Center
Bev Snow, Program Director, Windham Center

December 13, 2004

Susan M. Wehry, M.D.
Deputy Commissioner for Mental Health
Vermont Agency Of Human Services
Office of the Secretary
103 South Main Street
Waterbury, VT 05671-0201

Dear Dr. Wehry:

This letter serves to confirm the Retreat's interest in hosting a 16-bed acute care unit with capacity for intensive care patients at the Brattleboro Retreat. The Retreat proposes creating a total of 16 beds divided as follows: Ten (10) beds for general psychiatric acute care patients and a six (6) beds for psychiatric intensive care unit. There will be capacity to flex between the two units, altering the ratio of acute care to intensive care beds, with a total capacity remaining at 16. The total number of FTEs needed to provide care to the units is 39.6 - non-physician FTEs and one physician FTE. The staffing is made up of nurses, mental health workers, social workers, activity therapists, a program manager and two unit clerks.

The physical facilities at the Retreat would need renovation in order to accommodate the configuration described above. Without a complete understanding of patient needs, it is difficult to provide a detailed cost estimate at this time.

This letter of interest is conditioned upon a more detailed understanding of the clinical needs of patients, the development of adequate step-down services and linkages between the levels of care as described by the VSH Futures Group.

I hope this is helpful to you in confirming the Retreat's interest in providing services to patients currently being served at Vermont State Hospital. I look forward to continuing to work with you to meet the needs of individuals with mental health and substance abuse problems in Vermont.

Sincerely,

Richard T. Palmisano
President and Chief Executive Officer
TP/ban

cc: Julie Peterson, Chair, Board of Trustees
Beatrice Grause, President/CEO V AHHS

Fletcher Allen Health Care

16 December 2004

Susan Wehry, M.D., Deputy Commissioner of Health for Mental Health
Vermont Department of Health
108 Cherry Street
Burlington, Vermont 05401

Dear Susan:

Fletcher Allen Health Care expressed in an October 21 letter to the Mental Health Oversight Committee of the legislature an interest and willingness to enter a discussion about expanded inpatient psychiatry capacity in Burlington. The purpose of this letter is to reconfirm that interest and to provide a conceptual proposal as to how Fletcher Allen might become involved.

Before outlining our proposal, let me first express several caveats. First_ our proposal at this early stage merely defines the broad parameters for involvement by our organization, and a more detailed proposal obviously would require much further discussion and planning. Second, as we have discussed with you on previous occasions, Fletcher Allen is committed to ensuring full involvement by our neighbors, the advocates, and our community in matters relating to our psychiatric services. To that end, any planning that might develop will require the participation of Ward 1, the Mental Health Program Quality Committee, Howard Center for Human Services, and the City of Burlington, and any decision-making by Fletcher Allen will be subject to input from these and other important constituencies. Third, any decisions and actions taken by us as a result of this planning will ultimately require approval from our Board of Trustees.

With these caveats in mind, we are most interested in discussing further a proposal by which Fletcher Allen could become involved in the management and/or staffing of a state-owned inpatient psychiatry facility proximate to our Medical Center campus in Burlington, constructed and operated with state funding. As noted in our earlier letter, the size of the facility could be relatively flexible, depending on the statewide plan adopted by the Division of Mental Health and the legislature. However, because we do not have existing space or capacity for such a facility presently, new construction would be required with a commitment of state capital expenditures to cover the cost of this construction. Further, Fletcher Allen is not in a position to subsidize the costs of operating the facility and would need assurance of stable sources of funding during the period of our involvement in the facility.

We believe there are a number of factors that would favor the location of a new facility proximate to our existing hospital campus in Burlington. We currently operate approximately 28 psychiatry beds, but we are building two new inpatient units that are expected to be completed in the fall of 2005. At that time, we will have 28 beds, many of them single-occupancy, sixteen of them on the secure unit. These units are located near our emergency department and near hospital medical/surgical beds, so admissions from the Emergency Department to psychiatry are easily accomplished, as are transfers from and to medical/surgical units. We have 24-hour in-

house psychiatric coverage, excellent consultation resources from our colleagues, and we frequently manage complex psychiatric patients admitted to medical/surgical units for other care. The

overall system is well-organized and well-integrated. We are utilizing our full capacity now, and we expect that demand in our region will fill the additional beds as soon as they are built.

The public mental health system could capitalize on the existing capacity and programming by building a third (and potentially fourth, if that is desiraple) 16-bed unit nearby, then coordinating its programs with services now available at Fletcher Allen. All or part of this additional unit could be built and staffed to manage patients who cannot be managed on the existing secure unit. With a third unit, the Shepardson 6 secure unit could serve special functions: an admission/evaluation unit, a unit for patients requiring medical care (beyond minor interventions), and a unit for frail or vulnerable people who require a secure unit. The new unit could be designed and staffed to manage longer-term patients and more aggressive patients. Both secure units could be quite flexible about a broad range of patients who could be served on either unit, but future planning would have to include discussion of patient populations who would be served in these facilities.

The northwest Vermont region needs sub-acute transitional capacity for patients who are admitted but no longer need an inpatient level of care, and a successful, cost-effective inpatient program will require this kind of programming. The sub-acute facility would continue treatment of patients who are not well enough to live independently with available housing options in the region. The sub-acute facility should develop expertise for caring for patients who refuse medication. This could include motivational and educational programming or programming designed to optimize functioning and well being without medication. Any future clinical programs in Chittenden County should be developed in conjunction with Howard Center for Human Services, but this is particularly true of sub-acute care.

If these new units are close to the MCHV campus, the inpatient psychiatrist could follow the patient to different levels of care, from emergency presentation to transitional sub-acute program, enhancing continuity of care. The creation of inpatient and sub-acute care also offers an opportunity to co-locate other neuroscience programs within a new complex. These might include partial hospital services, clinical neurology programs, neurophysiology, and research.

There are three factors that limit inpatient management of aggression now: the physical plant, patient mix, and staffing. The Shepardson unit, and future inpatient units, will address the architectural needs for inpatient hospitalization. To increase our ability to manage more aggressive patients, we have to be able to separate them from elderly and frail patients, and from patients who have a history of aggressive trauma. This separation will require a third unit, but any increase in capacity would require a third unit anyway.

We are currently staffed to manage moderately aggressive patients, with rare one-to-one staffing. We have typically relied on the Vermont State Hospital to manage patients who require intensive supervision. We can adjust staffing to accommodate a different patient mix, with a resulting higher cost, provided that cost increases are addressed in a future affiliation agreement.

As we explore alternatives to the current Waterbury site, it is important to remember that all planning to date assumes the health and continued participation of our designated hospital system and community mental health agencies. The designated hospital system has functioned very well in our community-based system of care, and we must ensure that new programs do not harm any of the existing hospitals. The needed new capacity will be greater if any hospital reduces the number of psychiatry beds. The fortuitous geographic distribution of our hospitals permits local care and treatment coordination. Inpatient psychiatry units in general hospitals now function to provide immediate assessment and acute stabilization, a role that is defined by clinical considerations, third-party payment, and the cost to the community.

We hope that the proposal above complements and preserves the system of regional designated hospitals. If the program opportunities, academic affiliation, and Chittenden County location areof interest, we could proceed to analyze programs, staffing, and costs more precisely. At the appropriate time, we can also convene major stakeholders to elaborate these preliminary ideas.

Sincerely,

Robert Pierattini, M.D., Physician Leader and Chair
FAHC Psychiatry Service, UVM Department of Psychiatry

December 22, 2004

Dr. Susan Wehry
Deputy Commissioner, Mental Health 103 South Main Street
Weeks Building
Waterbury, VT 05671-1601

Dear Dr. Wehry:

Response to request for information:

Services for Patients Currently Hospitalized at VSH

Rutland Mental Health Services fully endorses Rutland Regional Medical Center's desire to pursue the development of a Psychiatric Intensive Care Unit and expand our mutual efforts in serving involuntary psychiatric admissions. We believe that an appropriate continuum of services must include psychiatric intensive care and inpatient care, subacute care and residential services. To that end, Rutland Mental Health Services and Rutland Regional Medical Center are collaboratively willing to explore the development of sub-acute and residential services in the greater Rutland area. Additionally, I have had the opportunity to speak with Judith Hayward of Health Care and Rehabilitation Services of Southeastern Vermont, and we will mutually explore strategies to develop a full continuum of services for Southern Vermont. This will involve discussions with Br_ttleboro Retreat, Springfield Hospital and United Counseling Services.

I wish to thank you for the opportunity to express our mutual interest in better serving the needs of Vermonters. Should you wish any further information, please feel free to contact me.

Sincerely,

Mark G. Monson
President and Chief Executive Officer

cc:

Judith Hayward
Tom Huebner

December 7, 2004

Dr. Susan Wehry
Deputy Commissioner, Mental Health 103 South Main Street
Weeks Building
Waterbury, VT 05671-1601

Dear Dr. Wehry:

Rutland Regional Medical Center (RRMC) wishes to express formal interest in pursuing the development of a Psychiatric Intensive Care Dnit (PICD), and to expand our efforts in serving involuntary psychiatric admissions. Our preliminary plan involves the development of an eight bed PICD, located adjacent to our current existing nineteen bed General Psychiatric Dnit. This would require extensive renovation and relocation of an existing nursing unit.

The PICD would serve patients with poor behavioral control suggesting a high risk of suicide, violence or property destruction. . Additionally, the PICD would be utilized for individuals who are unable to tolerate environmental stimulation ofthe General Psychiatric Dnit, and for individuals who have regressed into a confused or disoriented state with evidence of potential inadvertent danger to self and others. The PICD would have the potential flex from five beds to eight beds depending on the needs of the patient population.

In addition to developing a PICD, RRMC proposes to make available an additional nine existing acute psychiatric beds, which are currently under-utilized. A significant benefit of the addition ofthese nine beds is that little or no renovation would be required. Thus, psychiatric capacity at RRMC could be increased to 17 beds through the addition of the eight bed PICD, and maximizing existing underutilized capacity. A total of 27 psychiatric beds would be available to voluntary and/or involuntary patients throughout Vermont. Approximately, forty two new staff members would be hired in order to appropriately respond to the acuity of the target patient population.

We wish to thank you for the opportunity to express out interest in better serving the needs of Vermonters. Should you wish any further information, please feel free to contact us.

Sincerely,

Mark Monson
Vice President of Clinical Operations

Thomas W. Huebner
President & CEO

E-mail received on January 3, 2005 from Stephen Broer, of Northwestern Counseling Service and Support.

Susan,

My apologies for not sending you our agency's response to your Request for Information. I was away on vacation and returned today and did not have time to put together a formal response. I have been in contact with Nick Emlen from the Council and Ted Mable, our Executive Director. Nick informs me there will be other opportunities to share our thoughts and interest in supporting a more substantive community continuum of care for adults with severe and persistent mental illness.

In addition to our participating in the CRT Directors discussions that resulted in the 11/30/04 memo to the VSH Futures Committee and our support for the concept of a private/public partnership to replace VSH as we know it, we value our collaboration with neighboring Designated Agencies and Designated Hospitals. With regards to specific service components, our Standing Committee has been discussing a range of peer support options. We have also been exploring ways to increase our capacity to prevent hospitalization through our two residential programs (22 Upper Weldon & 174 North Main Street) as well as other alternatives. With additional support, each of our System of Care Local Priorities (2004-2007) can be modified to target hospital diversion, transition from hospitalization, and increase the overall quality of life for the consumers in Franklin and Grand Isle counties.

We look forward to participating in future discussions related to this important need area. I will be at the CRT Director's meeting on Friday to review outcomes from your meeting tomorrow.

Sincerely,

Steve Broer, Psy.D.
Director, Behavioral Health Services
Northwestern Counseling & Support Services
107 Fisher Pond Road
St. Albans, VT 05478
(802) 524-6555 x233

Appendix 21

VERMONT STATE HOSPITAL ADVISORY GROUP
MEMBERSHIP LIST 12/1/04

Charlie Biss, Director
Dept of Health, Division of Mental Health
Children's Mental Health

Kevin Buchanan, MD
Clara Martin Center
Community Psychiatrists

Nicole Dewing
VT State Employee Association

Representative Anne Donahue
Mental Health Legislative Oversight
Committee & Consumer Advocate

Senator William Doyle
Legislative Oversight Committee

Valerie Dubois
Vermont State Hospital
Nursing Staff

Paul Dupre, Executive Director
Washington County Mental Health
VT Council of Developmental & Mental
Health Services

David Fassler
Otter Creek Associates
Private Mental Health Providers

Cynthia Folino
Former VSH Patient

Jerry Goessel, Executive Director
NAMI-VT
Families

Bea Grause, Executive Director
VAHHS
Hospital Association

Anne Jerman
Vermont State Hospital
VSH Management

Ken Libertoff, Executive Director
Vermont Association for Mental Health

John Malloy, MD
Vermont State Hospital
VSH Psychiatrists

Jack McCullough
Mental Health Law Project

Bill Newhall
Consumer Advocate

Sally Parrish
Consumer

Kathy Pittaway
Developmental Services Representative

Paul Poirier
Vermont Protection & Advocacy

Jeff Rothenberg, CRT Director
Clara Martin Center
CRT Council

Terry Rowe, Executive Director
Vermont State Hospital

Sister Janice Ryan, Deputy Commissioner
Dept of Corrections

Tom Simpatico, MD, Medical Director
Vermont State Hospital

Senator Diane Snelling
Legislative Oversight Committee

Jo Ellen Swaine, Chief of Social Work
Vermont State Hospital
VSH Social Workers

Peter Thomashow, MD
Central Vermont Hospital
Hospital Psychiatrists

Xenia Williams
Former VSH Patient & Consumer Advocate

STAFF

Paul Blake, Mental Health Director
Dept of Health, Division of Mental Health

Beth Tanzman
Adult CMH Programs Director
Dept of Health, Division of Mental Health

Susan Wehry, MD
Deputy Commissioner
Dept of Health, Division of Mental Health

FACILITATOR:

Gretchen Cherington
GC Consulting

OTHER MEMBERS WHO HAVE SERVED:

Cheyenne Running Deer Hunter
Consumer Advocate

Gerhard Andres
Recent VSH Patient

Linda Corey, Executive Director
Vermont Psychiatric Survivors
Consumer Advocate